AN EPITOME OF MENTAL DISORDERS

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A Practical Guide to Ætiology, Diagnosis, and Treatment

FOR PRACTITIONERS, ASYLUM, AND R.A.M.C. MEDICAL OFFICERS

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PREFACE

This little book is not intended for students of medicine, but for practitioners and assistant medical officers in asylums. The writer has not aspired to write a textbook of psychiatry, but a concise practical aid to the diagnosis and treatment of the more common varieties of mental disorder as met with in general practice and lunatic asylums.

The works of standard authors have of course been freely consulted. A certain number of alienists deny the existence as clinical entities of nearly all forms of insanity, and are content to await with patience the time when pathology shall elucidate the problems of ætiology and classification for good and all.

Although we are at present, in most cases, only justified in the use of the term syndrome as applied to mental disorders, that attitude the present writer ventures to think is the negation of all clinical progress, and moreover tends directly to discourage the study of insanity by practitioners who have only facilities for clinical investigation.

It is hoped that an inevitable dogmatism of style in Part I will be pardoned. In a summary of this nature one cannot be continually prefixing "in the majority of cases" "in its typical form" etc. It is the typical form that is described.

It is also hoped that the division into chapters devoted

to states of Excitement, Depression, Stupor, etc., will facilitate the diagnosis, etc., of individual cases. It is an easy matter as a rule to decide at once the general clinical colouring of a case, whether the most prominent features produce a picture of stupor or of excitement, for example, and the chapter devoted to the appropriate classes can be consulted. Of course these divisions are entirely arbitrary and betoken no relationship between the very diverse syndromes thus grouped into chapters to render reference easy.

The classification, adapted from Tanzi, is set out on the following page, and like all classifications of mental disorders based upon ætiology, is provisional, and in some cases more or less hypothetical.

In enumerating symptoms a constant order and psychological systematization have been avoided: and it is especially wished to impress upon the reader that it is not the incidence of individual symptoms that forms the basis of the clinical distinction of the varieties of insanity, but the presence of some symptoms *together with* others, interdependent, or interacting and due perhaps to a related pathological process.

Part II is more theoretical and discursive. In it the less well defined mental disorders are briefly discussed. A Glossary of psychological terms used will be found at the end of the book.

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CLASSIFICATION OF MENTAL DISORDERS

DISORDERS IN WHICH THE HEREDITARY FACTOR IS ESSENTIAL OR IMPORTANT

Imbecility
Paranoia
Dementia præcox
Persecutory hypochondria
Manic-depressive insanity
Psychasthenia
Hysteria
Epileptic insanity

DISORDERS IN WHICH THE HEREDITARY FACTOR IS NEGLIGIBLE

Toxic

- Acute endogenous poisonings
  - From exhaustion, psychical stress, etc. → Amentia
    - Agitata.
    - Attonita.
    - Paranoides.
  - Uræmic delirium
  - → Acute Confusional Insanity
- Acute exogenous poisonings
  - From bacterial toxins, *e. g.* fevers, pyogenic infections, chorea, secondary syphilis, etc.
  - From drugs, *e.g.* morphia, cocaine, alcohol (delirium)
  - → Acute Confusional Insanity
- Subacute and chronic endogenous poisonings → Thyroid psychoses
- Subacute and chronic endogenous poisonings → Alcoholic syndromes
  - Hallucinatory delusions
  - Korsakoff's syndrome
  - Alcoholic "paranoia"
  - Pseudo-paresis

Organic	Cerebropathies	Congenital		Idiocy
		Acquired in later life	Cerebral tumours, trauma, hæmorrhage, etc.	Insanity with gross brain lesion
	Organic Degenerations	Arterio-pathic	Senile dementia (in part)	
			Arterio-sclerotic dementia	
		Syphilitic	General paralysis	

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CHAPTER VIII

SOME NOTES ON THE GENERAL CAUSATION AND TREATMENT OF MENTAL DISORDERS

In the preceding table of classification and under the headings of the Syndromes discussed in the following pages, some simple suggestions, at present usually regarded as correct, as to the ætiology of mental disorders, are implied or enumerated.

But just as it is the exception for one particular symptom to be pathognomonic of one form of insanity, so it is impossible for one causative factor alone to be at the root of a psychosis. This is true even of the few varieties of more or less known origin; for example, every chronic alcoholic does not become insane, every old person does not become a dement, every syphilitic does not develop General Paresis. Two factors are responsible for the development of mental disorder, the individual and the conditions to which he is subjected. The relative importance of each factor varies in the individuals and the types of mental disorder. The individual is the product of his pedigree, his personal ego, and his past reactions to his environment.

It is beyond the scope of this book to discuss the theories of ætiology at any length, fascinating as they are. It is only desired to indicate here the complicated nature of the subject, and to forewarn the student of insanity

against the pitfall of erroneous prognostication, and the fatalistic view of the inevitability of mental breakdown, or its permanency, in persons who from their heredity, physical metabolism, or environment, are more liable than others to develop some form of mental disorder.

Fortunately a man is an individual; he possesses a distinct ego peculiar to himself, and this may be potent enough to counteract all the recently inherited tendencies, as well as the buffets of disease and circumstance.

We frequently see a stock labelled as psychically degenerate (whatever that may mean) because a few members of the family in preceding generations have been insane. This is a misnomer—a confounding of inherited instability with degeneracy. The vast majority of the members of these unstable stocks never break down at all, and those that do, almost invariably succumb as the result of some superadded incidental and external cause.

On the other hand, quite commonly a typically so-called degenerative disease, such as dementia præcox, will crop up as it were as a "sport," in apparently perfectly sound stocks.

Insane heredity is very rarely direct and similar. In fact, all that can be strictly said to be inherited is a more or less strong tendency to *general* nervous or mental breakdown. The more hereditary types are indicated in the classification.

By appropriate education, suitable mode of life and environment, and in virtue of the individual's ego, an inherited tendency may frequently be defeated; and by the reverse state of affairs, repeated in succeeding generations, a sound stock may probably be rendered "degenerate" so far as all practical tests are concerned.

Some few stocks, contrary to the usual law of nature, exhibit a greater tendency towards insanity than towards

normality. Nearly all the members are wholly or partially insane. (Here again, however, the tendency is merely excessive as compared with unstable stocks. There is no hard and fast line between them.) These are regarded as the truly "degenerate" stocks, and they are very rare. Therefore, in the vast majority of cases of insane heredity all that is inherited is a psychical instability which renders its subject more liable to breakdown as the result of external causes than are normal people—an instability which varies in individuals and merges into the normal type.

This inherent tendency to insanity can with care very often be detected in childhood or adolescence, and its development into mental disease can in many cases be prevented by suitable measures. If family doctors only recognized signs of mental instability as such in their young patients, the incidence of mental disorders would be reducible in no small degree.

Children and adolescents who take to vice, exhibit explosions of uncontrollable temper, night-terrors, chronic irritability, vengefulness, love of solitude, valetudinarianism, moroseness, undue obstinacy or perversity, or egotism, apathy, absence of natural affection, etc., etc., are not merely crying out for rhubarb and soda, useful as these are as adjuncts; they are advertising their special liability to insanity. These mental traits are not infrequently accompanied by certain abnormalities of the physical structure in the unstable individual, known as stigmata of "degeneration"—an unjustifiable limitation. The less gross and more common stigmata are of exceedingly common occurrence in simple neurotics, in the unstable mental types now under consideration, and in people of artistic temperament (themselves for the most part of nervous type), by whom some of the best work of the world is done.

The reader who is interested in these stigmata, is referred to Dr. Stoddart's book on *Mind and its Disorders.*

Certain persons of psychopathic inheritance manifest a special temperament or diathesis, indicating an extra liability to special neurotic or psychical disorders.

Examples of this are seen in the case of certain epileptics, hysterics, some maniacs and melancholics, paranoiacs, etc., and will be discussed briefly under their own titles. It is not unlikely that we may succeed later in separating other temperaments or diatheses that are peculiarly liable to other special forms of psychosis. In any case these temperaments probably merely amount to signs of liability to special attacks of psychosis, etc., in virtue of which their possessors are more prone to such attacks, merely in a question of degree, than are other individuals lacking them. Peculiarities of psychical temperament are probably associated with inherent metabolic vasomotor and other bodily conditions, and the term temperament as used here is intended to include these physical diatheses where such are associated.

It is impossible to lay down rules for the treatment of children or adolescents of unstable mental type; each case must be treated upon its own merits.

As a general rule, it may be said that education should be directed towards the attainment of physical perfection rather than intellectual power and knowledge. The pursuit of sports and games should be encouraged, and school competition in general subjects prohibited. In most cases these children are much better sent to a good public school, but preferably a day one.

A great number suffer from adenoids and phimosis; these defects should be remedied by operation. Solitary, sensitive children are occasionally unable to stand the life of a public school, and the medical attendant must be

prepared for the failure of this part of his prescription.

If the boy (or girl) is unhappy or the signs of instability increase, he should be taken into the country, found some outdoor hobbies and some friends of like taste, and allowed to run wild, his education being carried on quietly at a local school.

It is better to have a comparatively ignorant boy than a lunatic. Neurasthenic and hysterical children should be kindly, but firmly, subjected to a hardening process of education. Seclusive, reserved types should be encouraged to air their troubles, discuss their difficulties and mix with their acquaintances.

These suggestions are for the most part truisms, but the importance of suitable nurture for children psychically unstable cannot be over-estimated. With regard to adolescents of this type, other points arise for consideration, the most important being the development of the sexual instinct.

The attempt at complete suppression of this instinct in unstable types makes for mental disorder; constant perverted indulgence has the same effect; sudden cessation of masturbation may have a similar effect. The aim of the physician, after he has explained matters, and caused his patient to face the conflict between the instinct and other forces, should be to render the instinct as unconscious as possible, and to find legitimate methods of sublimating it, *e. g.* by the gospel of games, by finding objects for the patient to love, *e. g.* relations, friends, religions, pets; and by treating masturbation, not as a crime, but as a symptom.

In brief, unstable children at puberty or before should have the sexual scheme of things told to them by a doctor, male or female, according to their own sex, and subsequently be given a short course of bromides. Young

people of this type should marry early, being duly warned of the necessity of moderation. Indeed, moderation in all things should be their golden rule.

The possibility of unstable children of such a marriage need not disturb us. The majority will probably make good citizens. If the other parent is also unstable, the progeny will be more likely to be the same, and some of them may become insane. But the tendency of nature is towards the normal. If either of the parent's stocks is truly (so-called) "degenerate," some of the children will almost certainly be so also.

Mott has shown, however, that in these more strongly hereditary types the insanity tends to occur at an earlier age in each succeeding generation.

Now imbecility is regarded as the final expression of the degeneration of the stock, and imbeciles stand a good chance in these days of being prevented from propagating their race—moreover, precocious dements, examples of the other often so-called typical degenerative condition, are subject in many cases to the same restrictions, viz. they are confined before they breed.

In this way, therefore, nature, true to her rule, gets back to the normal in the stock by eradicating the hopeless element.

Selfishness and egotism are predisposing causes of insanity. Altruism tends to keep a man sane. An altruist may get an incidental attack of mental disorder as the result of stress, but he almost invariably recovers; an egotist is a potential chronic lunatic. But it must be remembered that a man of exemplary conduct may be a great egotist.

This being the case, the physician and friends of unstable children and adolescents, should do their utmost to encourage an altruistic view of life, and an appropriate code of conduct in these potential psychopaths; so far

as their temperaments will permit, for there can be no manner of doubt that self-suppression, *i. e.* the suppression of the sum of powerful emotional tendencies and instincts of the individual, tends towards insanity in persons of neuropathic inheritance or type.

Speaking from a purely scientific point of view, the Christian religion admirably serves the former purpose, without necessitating the latter undesirable result, providing, as it does, for the legitimate dissipation of emotional complexes, both in feeling and mode of life, *e. g.*, love of God, of one's fellow men, philanthropy, etc. But the religion must not be a narrow egotistical one.

It is a common idea amongst the laity that religion sends people mad (this erroneous view is not unknown among medical men). The truth is that persons incubating insanity not infrequently suddenly begin to talk and think a good deal about religion (the occult force with which they are most familiar), and seize upon it as an explanation of abnormal thoughts and feelings inexplicable to them upon any ordinary grounds.

Similarly, debauchery seldom results in insanity; but incipient lunatics losing their control often take excessively to it. Neurasthenia does not predispose to mental disease, but many psychoses exhibit its symptoms in their early stages. An exception to this rule is the liability of acute neurasthenics to confusional attacks, the term neurasthenia being used here to include the asthenic and the anxiety varieties.

Marriage, as suggested above, predisposes towards sanity, and yet occasionally a mental breakdown follows closely upon it. These marriage psychoses generally occur in persons who marry relatively late in life.

Intellectual labour, however arduous, never sends anybody insane, provided that it is congenial. Uncon-

genial work involving a persistently unpleasant emotional tone, not uncommonly results in psychoses or neuroses.

Emotional disturbances of unpleasant nature generally, are potent causes of mental disorder in certain types; those most liable to be thus affected are persons of quiet, self-contained, self-controlled habit. Vivacious, impulsive, excitable and even hysterical people, seldom become insane. When they do, the form of insanity is not as a rule of a grave variety.

All the common conditions mentioned above as causes of mental disorder are mere co-operating factors in its production.

Incidentally, they are just as likely to result in the case of certain individuals in a neurosis.

To sum up, some of the following conditions by their interaction are the common causes of mental affections:

1. True so-called psychical degeneracy (often not requiring any conspicuous contributory causes).
2. Inherited or acquired instability.
3. Faulty up-bringing or environment.
4. Suppression of emotional complexes.
5. Changes in sexual metabolism, *e. g.*, adolescence, climacteric.
6. Unpleasant emotional states, whether sudden, such as fright; or prolonged, such as worry and unhappiness.
7. Physical affections, *e. g.*, exhausting illnesses.
8. Poisons, *e. g.*, alcohol.
9. Organic cerebral disease.
10. Egotism (often found in persons of unstable stock).

Hints for the treatment of the individual psychoses will be mentioned under their titles. They are mainly practical suggestions along medical lines.

These present brief notes ought perhaps to contain some reference to psychical treatment.

From personal experience of its application the present writer is not qualified to speak upon the subject of psycho-analysis—a process by which some forgotten or suppressed conflict is revived in the patient's mind with the idea of showing him how to tackle it upon scientific grounds, and so free him from some pathological symptoms which are supposed to be due to its unnatural suppression. The method is said to have done good in some cases, for the most part, I believe, border-line types, hysterics or psychasthenics, but owing to the length of time required for it it is beyond the scope of the majority of practitioners, whatever their views as to its value.

Psycho-analysis is of course always open to criticism that any success it has is due to the continual suggestion of recovery it supplies. And, perhaps not infrequently the suggestion without the analysis is equally efficacious. Even so, the main point is the recovery of the patient, and that appears to have followed the employment of psycho-analysis in some cases. (*See also* page 194, and Hysteria, p. 141)

I am afraid that there is some justification for the view that psycho-analysis is a form of mental vivisection, instructive to the operator but painful and at times unnecessary or harmful to the patient. I think there can be no doubt, in spite of isolated unwarranted assumptions on the part of its advocates, that it has furnished valuable information concerning psychical processes. But it seems to me, that though showing the patient his conflicts, psycho-analysis fails to supply him with the proper means of sublimation. To say that honest and sincere psycho-analysis is immoral is not only untrue but silly. A psycho-analysed person is enabled to realize what we have all been taught for two thousand years, that we are naturally selfish and more or less

wicked, that our instincts and personal tendencies if allowed free play are not in accordance with a mode of conduct productive of the best racial results, but there psycho-analysis though curing a neurosis for the time—stops.

There can be no manner of doubt that the personal influence and suggestion, conscious or unconscious, of the physician exercises a very great power for good over the patient. If not directly curative, which unfortunately it seldom is, it at least promotes his comfort and well-being, retards and at times checks the progress of the disease, and is invaluable in the management of him.

It is profoundly true that border-line, neurotic types, and incipient cases of insanity, with whom it is difficult to get *en rapport* (*not* by means of hypnotism), those that are not suggestible, those in whom one encounters an undue reticence, perversity or mental resistance, are the types most likely to develop definite insanity, and least likely to recover therefrom.

Therapeutic suggestive conversation with these early or border-line types of disorder is never wasted, nor for that matter, with any lucid mental patient. The methods to be pursued cannot be laid down; they are a question of sympathy, personality, and the type of patient.

Some old general practitioners, if they had the requisite knowledge of the workings of the sane and insane mind, would perhaps emulate some of the foremost psychiatrists of the day on this head. Unfortunately, prolonged residence in asylums rather tends to blunt the wider faculties of physicians, yet such a means of study is practically the only one available in this country.

PART I

COMMON TYPES OF INSANITY

CHAPTER I

STATES OF EXCITEMENT

1. MANIA

MANIA is now generally regarded as a phase of manic-depressive insanity, which is thought to be based upon a constitutional metabolic or temperamental condition, often hereditary, rendering its subjects more liable than are normal people to attacks of excitement or depression from slight or no very obvious external causes.

A few cases of mania manifest no phase of depression at any time, the majority exhibit a short stage preceding or terminating the attack of excitement, others alternate from one to the other with or without a period of equilibrium between.

Some persons develop a single isolated attack of this form of insanity, from which they recover, the majority have recurrences, others, after one or more attacks become permanently insane—according to the absence or presence and strength of the constitutional tendency and the nature of the mode of life and environment. Usually the single isolated attack of a lifetime indicates no particular manic depressive temperament (*i. e.*, tendency) in the patient, and none such is to be observed in his normal condition.

These single attacks usually follow definite external causes.

Symptoms

The chief features of acute mania are as follows (for Glossary *vide* p. 202) :—

1. Genuine intellectual and emotional excitement with proportionate motor unrest, "press of occupation," *i. e.*, the patient must always be doing and talking.

2. Incoherent speech due to rapid flow and change of ideas. This talking is disconnected, but not meaningless.

3. Keen perception, and hypersensitiveness to external impressions, with good comprehension and memory, and clearness about immediate surroundings.

4. Divertibility, *i. e.*, the patient's line of thought, conduct, and emotional tone can be altered by suggestion or by any chance percept. Passive attention is exaggerated, but voluntary not sustained.

5. Rapid changes in the emotional state, which is, however, always sincere. The prevailing tone is one of exaltation and boisterous cheerfulness.

6. Absence of hallucinations. Illusions may occur, both visual and auditory, resulting from faulty association of ideas due to their rapid flight. So, also, may transitory delusions in accordance with the mood (for periodic types of mania, p. 15).

7. Gradual onset as hypomania, a milder type of exaltation not unlike the early stages of physiological alcoholic intoxication.

Prognosis

The outlook for an individual attack is good : the majority of cases completely recover : but recurrence is almost the rule. After numerous attacks the patient becomes impaired in judgment and self-control ; he

loses his autocriticism, and exhibits some degree of weak-mindedness.

Some attacks of excitement never completely subside, but persist in an attenuated form, with more or less periodical exacerbations; thus presenting the picture of chronic mania. These chronic cases are prone to develop varying transitory and incoherent delusions.

In certain predisposed persons attacks of mania are periodical, and occur more or less regularly at intervals of a few years. Their individual attacks usually do not differ materially from those of the ordinary recurrent type, or the single isolated attack of a lifetime (which by the way is very rare, the majority of the single attacks, commonly dubbed mania, being cases of amentia), but they very frequently manifest more or less systematized delusions of paranoidal type (*vide* p. 61), which, more prominent during their periods of excitement, are never quite in abeyance in their so-called normal years.

It is not improbable that in these patients a paranoical temperament co-exists with the manic-depressive diathesis (*vide* p. 172).

Those cases which manifest delusions of a pleasant, more or less grandiose nature are easily distinguished as maniacs, because their ideas are in accordance with the exuberance and exhilaration present in that disease, the difference from ordinary maniacal attacks merely being, that the ideas usually transitory and disconnected have become fixed and connected.

There are other types, however, in which ideas of persecution and a mood of resentment or even slight depression are exhibited, masking in some degree the buoyancy of the maniac; and a peculiar mixture of maniacal, melancholic and paranoidal features is presented.

The maniacal basis, however, colours even the para-

noidal persecutory delusions with a certain egoistic self-importance, so that the patient, though persecuted, is not afraid, nor really unhappy, but rather flattered at the attention he thinks he excites, and inclined to imagine that he is a greater personage than he was previously aware of. The delusions are connected, highly improbable, but never intrinsically impossible under every conceivable combination of circumstances. There is complete collectedness, and good memory. Hallucinations are absent.

These cases are sometimes difficult to diagnose in their quieter periods, but when properly developed, they are distinguished from all other delusional states by the presence of the characteristic signs of mania, viz. true intellectual and emotional excitement with flight of ideas, and proportionate motor unrest, hyper-acute passive attention, defective voluntary attention, divertibility (except as regards the truth of the delusions), disconnected speech, together with complete collectedness and good memory.

The reader is advised to re-read these notes after considering the chapter devoted to delusional states.

Differential Diagnosis of Mania will be discussed under subsequent headings.

Treatment

The patient should be put to bed in a room containing no bedstead, nor any dangerous or breakable articles. Except in the worst cases, friendly persuasion can do wonders with maniacs. If they cannot be coaxed to remain in bed, as a rule they can be induced to refrain from active mischief.

When called to a case, observe that the bladder is not distended; give an aperient, *e. g.*, 4 or 5 grains each of

calomel and jalapin, and when examining the physical condition of the patient, remember to test the urine. As soon as the bowels have acted, sulphonal should be administered—20 grains for a man, 15 for a woman, twice daily. It may be given suspended in mucilage, or preferably as a powder, followed by half a pint of hot milk.

After two or three days the drug should be discontinued for one day, then exhibited again for another two or three, and stopped again for two days—and so on until the attack subsides. In addition, paraldehyde in 1 or 2 drachm doses may be administered between the doses of sulphonal, and at night if necessary.

The food in mania should be nourishing and easily digested, but no special dietary is indicated.

Under the above régime the majority of cases are both controlled and enabled to sleep. Very violent patients, however, may need an occasional dose of hyoscine hydrobromide hypodermically. Eight minims of 1 in 800 solution is a safe dose, and may be repeated in three hours if required. But unmanageable maniacs as a rule mean a feeble physician.

Of course, all sedatives must be given in accordance with general medical principles. They are contra-indicated in serious bodily illness and feebleness—with some exceptions. Sulphonal must not be used if renal or alimentary diseases or constipation be present, nor hyoscine in cardio-vascular disease or senility.

Chloralamide, paraldehyde, and morphia are safe, and may be of service. Morphia, however, may sometimes increase the excitement of maniacs.

A maniacal patient should be examined daily for injuries, and also after any struggle, especial attention being paid to the ribs. He should be persuaded to walk, and if any unsteadiness of gait manifests itself, the sul-

phonal must be stopped until this symptom disappears. Care must be always taken that the bowels are kept open to allow the elimination of that drug.

The urine of patients on sulphonal should be seen daily, and if any darkening in colour be noted, tested for hæmatoporphyrin. If the latter is present, stop the sulphonal at once, and treat for poisoning. The writer has never seen symptoms of sulphonal poisoning arise from the doses advocated here, but idiosyncrasy is said to exist in some persons, in whose case small doses produce toxæmic symptoms.

Chronic maniacs can be kept on 20 grains of sulphonal daily for an indefinite period without harm, provided the drug is discontinued for a few days at intervals of a week or so, *and* the bowels are kept open.

An excellent treatment for many forms of excitement, which enables one to dispense in a large measure with sedatives, is the continuous warm bath; but in the patient's home, as well as in many asylums, no apparatus for this is available. The temperature of the water should be 98° F., and the period in the bath increased from half an hour on the first day to five hours on the seventh.

Some cases of acute mania terminate in a short attack of exhaustion. One must be prepared for this contingency, and when it arises, replace sedatives by stimulants such as strychnine and alcohol. Not uncommonly instead of exhaustion, an attack of depression or stupor supervenes.

2. EXCITED PHASES IN DEMENTIA PRÆCOX

Dementia Præcox is a form of insanity occurring chiefly in adolescents and tending to permanent dementia

of a characteristic type. The ætiology is obscure, but it has been suggested with some degree of probability that the disease is due to a chronic auto-intoxication in so-called degenerate persons. There is some presumptive evidence that this poison arises from disordered metabolism in the sexual glands. Quiet, reserved, egotistical adolescents are chiefly attacked.

A family history of insanity is almost invariably forthcoming, and the disease is particularly prone to attack brothers and sisters.

Dementia præcox exhibits various forms and phases besides excitement. These will be discussed under subsequent headings. States of excitement initiate some cases, and occur in the majority during the course of the disease.

Symptoms of Excitement in Dementia Præcox

1. The motor excitement may be considerable. The patient perhaps jumps about, gesticulates and shouts. He is often dirty in habits, destructive, degraded, and cleverly violent. He grimaces, grins and executes purposeless acts. His conduct has often a pronounced sexual colouring.

As a rule he manifests, in addition, some definite signs of katatonia or catalepsy (*vide* Glossary, pp. 202, 203), *e. g.*, rigid attitudes, alternating with causeless violence, or stereotypism in movements. But with all this motor unrest there is—

2. Little or no intellectual or emotional excitation. The excited conduct does not appear sincere, owing to the co-existence of a fundamental and characteristic emotional dullness.

3. Disjointed, meaningless, and absurd speech; a degree of incoherence is present out of all proportion

to the excitement. Verbigeration, *i. e.*, the continual repetition of one word or phrase, is common.

4. Comprehension, perception, and memory are good, and there is no true disorientation (*vide* Glossary).

5. Divertibility is absent, on the contrary, the reverse is often manifest, viz., negativism, a chronic impulse to do the exact opposite of what is suggested.

6. Auditory hallucinations are exceedingly common, if not present in every case, and visual, tactile, coenesthetic hallucinations are not uncommon. Shifting transitory delusions of grandeur or persecution or of an impersonal nature accompany the hallucinations. The erroneous ideas are often intrinsically absurd and impossible.

Prognosis

These attacks of excitement are short, usually of only a few days' or weeks' duration. Those which apparently initiate the disease sometimes result in almost complete recovery, but the mischief is merely latent, and further developments are certain. Usually, however, some abnormality remains after the subsidence of the excitement, varying from simple dulling of interest in life, to definite clinical pictures of dementia præcox.

Differential Diagnosis from Mania

1. Symptoms present in dementia præcox, but absent in mania—
   (1) Basic emotional dullness.
   (2) Motiveless acts, absurd or degraded conduct.
   (3) Meaningless talking, and verbigeration.
   (4) Hallucinations.
   (5) The katatonic or cataleptic syndrome in part or whole (*vide* Glossary).

2. Symptoms present in mania, but absent in dementia præcox :—
   (1) Marked intellectual excitement with flight of ideas.
   (2) Genuine emotional exuberance.
   (3) Press of occupation.
   (4) Divertibility.
   (5) Pride or *amour propre*.

Some of the initial states of excitement in dementia præcox approximate more closely to the clinical picture of mania. They may show no obvious katatonia, hallucinations may be difficult to make out, and senseless speech absent. Careful observation, however, will soon indicate the true condition. Perhaps, in the midst of a bout of violence and apparent rage, the patient may smile vacantly. This vacant smile, guiltless of external cause, free from mirth, and silly, is characteristic of dementia præcox.

Affectation of manner uncoloured by humour, pedantry, sudden weeping aloud without cause, or other indications of sham emotions, in addition to motiveless conduct, are conclusive evidence of that disease. Coining new words ("neologisms"), intrinsically absurd and impossible delusions should at once put one on the same track.

Finally, it may be stated that most cases of pathological excitement occurring in adolescence are manifestations of dementia præcox.

Treatment

The general management of the excitement should be conducted on the same lines as that of mania. Moral suasion however is useless, as the patients usually act in opposition to any suggestion, and misconduct themselves

from perversity. This is doubtless due to negativism, but it creates an impression of deliberate malice. Sulphonal is not a good drug for these cases. If pushed it renders them less troublesome, but at the expense of safety in dosage.

Chloral hydrate in doses of 20 grains t.d. or a mixture of bromides and Cannabis Indica answers fairly well as a sedative. Nothing seems to influence the course of the malady of which this excitement is an expression. Cases remain stationary or degenerate into dementia, in spite of any treatment so far discovered.

3. ACUTE CONFUSIONAL INSANITY

By this term is meant an acute semi-conscious state of confusion accompanied by disorientation, hallucinations, and signs of bodily illness, which terminates in recovery or death.

The conditions included under the present heading are, agitated amentia, acute delirium, delirious mania, delirium of collapse, exhaustion and intoxication psychosis. These various names are applied to disorders presenting essentially the same symptoms in different degrees of intensity, acute delirium and the so-called delirium of collapse being the graver forms.

Intoxication is regarded as the root cause, and for its ætiology the reader is referred to the Table of Classification on page ix.

Amentia agitata may be taken as typical of excited forms of acute confusional insanity; varieties of the latter due to specific poisons differ mainly from amentia, in presenting physical signs of the causative toxins, amentia being the result of an auto-intoxication of unknown nature.

Symptoms of Amentia Agitata

1. A high degree of excitement with great motor unrest, varying from constant picking at bedclothes and tossing about, to violent rushing and struggling—purposeless or, at best, defensive acts the result of internal not external stimuli.

2. Great confusion of speech. The talking is meaningless and unintelligible, often showing disintegration of words, and due to a rapid confused flight of imperfectly developed ideas.

3. Clouding of consciousness. Perception (*vide* Glossary) is confused and inhibited. The patient is engrossed in himself and has very little consciousness of his surroundings. He is in a large measure impervious to external impressions. Passive attention is absent; disorientation in time and space, of course, present.

4. Emotionally, agitation and apprehension predominate, but there are rapid changes; the patient may be terrified, amorous, and hilarious in turn.

5. Hallucinations are incessant, and dominate the entire picture; the patient's mind is mainly occupied with these.

6. There may be loss of the sense of personal identity.

7. The onset is always acute.

8. Brief lucid intervals.

9. Physical signs of illness, varying from anæmia and emaciation to a grave typhoid state.

10. On recovery, amnesia for incidents occurring during the attack.

Prognosis

These cases either recover completely, or die. Physical recovery involves mental cure. The main cause of death is collapse, which may occur within a few days of the onset

of the delirium. Continuous fever is of bad prognostic significance, so also is a "typhoid-state." Dirty, degraded and destructive habits are said to be indicative of a serious attack, and the outlook is also considered worse in cases manifesting remissions lasting for some days.

Finally, some patients are said to have more or less periodical attacks at intervals of some years.

Differential Diagnosis

(*a*) From Mania :—

1. Signs present in amentia agitata and absent in mania :
   (1) Abrupt onset.
   (2) Semi-consciousness, with inhibited perception, complete disorientation and great confusion.
   (3) Incessant hallucinations.
   (4) Confusion of speech, *i. e.*, fragmentary, senseless talking.
   (5) Apparently purposeless conduct.
   (6) Rapid emotional changes, arising from within. Apprehension, when present.
   (7) Physical signs of bodily illness.
2. Signs present in mania and absent in amentia agitata —
   (1) Hypersensitiveness to external impressions, with keen passive attention.
   (2) Accessibility and divertibility (*vide* Glossary).
   (3) General alertness, and good comprehension and memory.

(*b*) From Excitement in Dementia Præcox :—

1. Signs present in amentia agitata and absent in dementia præcox :—

(1) Semi-consciousness with inhibited perception and complete disorientation.
(2) Genuine intellectual excitement, with flight of ideas.
(3) Deep and sincere emotional states.
(4) Physical signs of bodily illness.

2. Signs present in dementia præcox and absent in amentia agitata :—
(1) Basic emotional vacuity.
(2) Katatonia or catalepsy, in some form (but *see* p. 183).
(3) Good comprehension and memory.

Treatment

It must be continually borne in mind that the patient is gravely ill.

On receiving a case of confusional excitement, be prepared for signs of fevers, uræmia, drug poisonings, meningitis, etc. These, if present, should be treated as far as possible on general lines.

See that the bladder is not distended, test the urine, take the temperature, if possible, and examine the patient physically. These patients are not suitable for treatment in their homes. The patient should be put into an asylum, and into a padded room, empty except for mattress and bedclothes. The door must, of course, be open, and a nurse stationed at it. There are five essentials to be aimed at in treatment.

1. To feed the patient.
2. To procure rest and sleep.
3. To prevent injury.
4. To keep the bowels and kidneys active.
5. To keep the patient clean.

1. Food.—Milk, eggs, beef-tea, and other nourishing

fluids should alone be given. If the patient will not eat, he must be fed by the stomach tube without delay. If he is feeble, give digitalin and strychnine hypodermically before the feed. Then wash out the stomach with saline, and afterwards administer the following mixture :— Milk (warm), 1½ pints ; 2 eggs ; 1 oz. sugar ; Valentine's meat juice, 2 drachms ; brandy, 1 oz.

A similar feed must be repeated three times a day, necessary medicine being added when required. If the stomach does not retain approximately the necessary quantity, the latter must be reduced, the strength diluted, and the feeding be more frequent.

In very severe cases, which cannot retain any food, Dr. Stoddart recommends the administration of chloroform for tube feeding, the anæsthetic being kept going for one hour after the feed.

Bad cases need stimulants. Brandy is probably the best, and may be given in one or two ounce doses every three or four hours.

2. Rest and Sleep.—It is often exceedingly difficult to procure sleep for these patients. The use of sedatives is necessarily limited owing to the danger of collapse. Continuous warm baths as described for mania are useful, but care must be taken that they do not further exhaust the patient. Sulphonal, trional, veronal, etc., should not be given ; chloral and bromides are not recommended. Paraldehyde is perhaps the best drug. It may be given in 1½ or 2 drachm doses every four hours, but unfortunately it soon loses its effect. In the majority of cases, chloralamide may also be quite safely used in doses of 10 to 15 grains. Morphia and its allies may be of value.

Brandy is soothing, as well as a cardiac stimulant, and is a useful auxiliary sedative in somewhat larger doses than those mentioned above.

3. Immunity from Injury.—This is obtained by the

use of a padded room and the attendant at the door. The patient should, of course, be examined daily.

4. Active Bowels and Kidneys.—If the patient is not too excited an enema should be given on admission. If it is not effectual it must be repeated in two hours. When one has information that the bowels have acted within the previous three days, an aperient may be administered, preferably calomel. If neither an enema nor aperient can be given, and the bowels do not act in twenty-four hours, the patient must be fed by tube with a purgative, *e. g.*, emulsion of castor oil (1 in 2) in a pint of warm milk. If vomiting occurs, and the bowels still remain obstinate, chloroform must be resorted to as suggested above; the stomach washed out; a feed, and aperient given by tube, the bowels being cleared out at the same time.

The action of the kidneys may be promoted by giving plenty of barley water, if possible. Rectal injections have been found of value in cases that retain them.

5. Cleanliness, Internal and External.—In addition to the hints under the preceding heading, which make for internal cleanliness, the mouth and teeth must be scrupulously attended to. After each meal, the teeth and gums should be swabbed over with some innocuous antiseptic, such as glycerine acid boric and hydrogen peroxide.

The administration of lactic acid organisms, several preparations of which are on the market, should prove useful in lessening intestinal intoxication but it must be remembered that these tend to produce constipation.

The skin of the back, and other parts of the body liable to pressure, should be painted with some hardening preparation, *e. g.*, a paste made of zinc oxide, starch, and dilute methylated spirit. This should be a routine procedure three times daily, additional paintings following

all washing of the patient. The latter is necessarily frequent, as these cases are almost invariably "wet and dirty."

Collapse, should it occur, must be treated on general medical lines, by stimulants, saline infusions, pituitarin, etc.

Finally, the patient should be confined to bed for a week or more, after the attack has subsided, preferably in the open air, and strengthened by abundant nourishing foods and tonics.

4. STATES OF EXCITEMENT IN GENERAL PARALYSIS OF THE INSANE

Phases of excitement may occur at what is regarded as the onset of the disease, at intervals during its progress, or may constitute the entire clinical course.

The recurrent attacks are sometimes followed by remissions of some months' duration, but the patient deteriorates mentally after each.

The disease occasionally takes the form of a continuous state of excitement, resulting in death in a few months. This is so-called "galloping G.P.I." The excitement in G.P.I. is often of mixed type, but for convenience in diagnosis two main varieties may be described.

(A) MANIACAL EXCITEMENT IN G.P.I.

As the name implies, this variety in a general way resembles mania, therefore the distinctions from that affection alone need be given. The above noted attacks with remissions are not infrequently of this type, thus increasing the general similarity between the two affections.

1. Distinctions from Mania

1. In G.P.I. there is relative emotional dullness, producing a disproportion between the depth of emotion indicated by the statements, conduct, and general demeanour.

2. The paralytic has feeble volition, and a weak changeability of mood. He is more divertible than the maniac, both in conduct and emotional tone, being easily moved from laughter to tears. He has no increase of passive attention, but on the contrary, marked deficiency with a generally decreased reaction to external stimuli.

3. Absurd disconnected delusions of grandeur of expansive type, *i. e.*, amplified to overcome suggested objections, are almost invariably present in excited paralytics. Maniacs may have similar delusions, but they are not so obviously absurd, and owing to the maniac's flight of ideas, hardly ever expansive ; moreover, they are usually transitory fancies of doubtful certitude, not delusional convictions.

4. Obvious evidence of the invariable intellectual deterioration characteristic of G.P.I., such as retarded perception and ideation, defective memory for times and dates, inability to do simple sums, etc., often exists, even in the early states of excitement. Occasionally complete disorientation is present, which is never the case in uncomplicated mania.

5. From the above symptoms it will be apparent that in G.P.I. there is none of the keen alertness of the maniac, on the contrary a general air of futility and ineffectiveness pervades the demeanour and conduct of the excited paralytic.

6. Some physical signs of G.P.I. are usually present. Amimia in the lower part of the face can often be made out when the motor excitement precludes the examination of reflexes, etc.

In a word, it is the signs of the degenerative process both mental and physical in G.P.I. that form the basis of the distinctions between its excited phase, and mania.

2. Diagnosis of Maniacal Excitement in G.P.I. from that in Dementia Præcox

There is usually no difficulty in distinguishing between these two conditions, though the symptoms appear somewhat similar on paper. The following are the chief points to be noticed :—

In G.P.I. are present :

1. Marked divertibility of mood and conduct, instability of emotional state, euphoria and exaltation predominating.
2. More continuous motor excitement and restlessness.
3. Genuine, though superficial emotional states.
4. Expansive delusions.
5. Paralytic demential symptoms (*vide supra*) and physical signs (*vide* p. 99.)
6. With regard to conduct, the paralytic's actions are disproportionate to his emotional state or ideas, but not motiveless.

In dementia præcox are present :

1. Meaningless remarks or unintelligible talking.
2. Katatonia.[1]
3. Purposeless acts.

[1] Some excited paralytics strike attitudes, indulge in silly antics, are transitorily negativistic ; and generally play the fool. But the picture of katatonia is not complete ; it is marred by the essential futility of the paralytic, who, as it were, cannot be katatonic efficiently. He can be persuaded out of his negativism ; his euphoria will obtrude itself, and his antics, etc., are rather the result of his euphoria, or of a desire for display and parade, than of a blind internal impulse as in the case of dementia præcox.

4. Apparently deliberate, malicious and unprovoked misconduct.

5. Auditory hallucinations (cf. paralytic delirium).

3. Distinctions from Acute Confusional Insanity

The form of paralytic excitement under consideration is not likely to be confounded with amentia. The confused dreamlike condition with the constant hallucinations and self-absorption, together with the physical signs of illness are distinctive signs of the latter. Add to these the genuinely lively emotional state of the ament, the complete disorientation, absence (except very transitorily) of euphoria ; and one has a clinical picture quite unlike maniacal G.P.I.

(B) PARALYTIC DELIRIUM

This state is probably to be looked upon as an intoxication syndrome or amential episode occurring in the course of general paralysis. Hence its symptomatology resembles more or less closely that of acute confusional insanity. The following are useful points in distinguishing the paralytic variety :—

1. A slighter degree of clouding of consciousness and confusion, with greater accessibility, which may enable one to demonstrate :

2. Divertibility of mood and conduct.

3. A much less lively and less deep emotional state, with more continuous exaltation and little, if any, apprehension.

4. More intelligible speech.

5. An undercurrent of euphoria colouring all moods, flaring out at times in the form of absurd grandiose delusions.

6. Less prominent hallucinations,

7. Less rapid ideation.

8. Absence of marked cachexia (except in long-standing cases of G.P.I. in which the history or previous knowledge of the case precludes any doubt about the diagnosis) and the presence of physical signs of G.P.I.

9. Short duration, a few hours or days.

The galloping variety of G.P.I. not infrequently shows phases of delirium, in which case the distinctions from amentia given under sections 8 and 9 do not apply.

Prognosis

The nature of the attacks of excitement has been briefly outlined at the beginning of this section. G.P.I. itself is at present an incurable disease, and, moreover, usually fatal in three years. The galloping form has been referred to. The variety taking the form of a series of more or less isolated attacks, may extend over ten years.

Treatment

The treatment of excitement in G.P.I. is much the same as that of mania and acute confusional insanity. Special attention should be paid to the skin, and the fragility of the bones in some paralytics must be borne in mind. Difficulty in deglutition or a tendency to bolt food—involving a risk of choking—must be guarded against by restricting the diet to slops, and if necessary, by feeding the patient with a spoon.

For the various methods that have been recommended for the treatment of the disease *per se*, more detailed works must be consulted. Since the discovery of the spirochæta pallida in the brains of paralytics and the direct application of anti-syphilitic remedies by subarachnoid or intrathecal injection the prospect of finding a cure has been improved.

5. DELIRIUM TREMENS

Delirium tremens is a form of acute confusional insanity occurring in chronic alcoholics as the result of a secondary auto-intoxication, generally regarded as induced by an over-production of anti-bodies to alcohol.

It does not always take the typical form described below. Masked epilepsy is sometimes co-existent with chronic alcoholism: this coincidence is well-known in the case of dipsomania, and it is occasionally seen in delirium tremens.

Great stupefaction, blind violence, and also convulsions, (unless these latter are due to uræmia) may be indications that the patient is also subject to epilepsy at other times, but such is not a necessary deduction.

Symptoms

1. Gradual onset, with restless apprehension and isolated elementary visual hallucinations.
2. Motor excitement, the result of apprehension.
3. Rambling, but intelligible speech, often blurred and tremulous.
4. Some clouding of consciousness. Real perceptions are mingled with false, so that the semi-consciousness is not deep, but disorientation is present.
5. Accessibility, except in the very worst periods of grave cases.
6. Divertibility (subject of course to 5) in mood, thought and action. The attention can be temporarily distracted from imaginary delirious events and hallucinations, to the immediate surroundings.
7. Numerous vivid hallucinations, chiefly visual, and often taking the form of reptiles, vermin, devils, etc., fantastic dream-like illusions and delusions.

8. A mingled apprehensive and humorous mood.

9. Frequent brief lucid intervals, during which the patient is clear and collected and understands his condition, treats it as a joke, but is really rather frightened. He knows the nature of his surroundings, but is confused about time. His memory, except for the period of his delirium is good. These, be it understood during the lucid periods.

10. Physical signs of alcoholism : *e.g.*, coarse tremor of hands, lips and tongue, flushed face, sweating, smell of alcohol. None of these signs are invariably present.

Prognosis

The majority of cases recover completely in a few days, usually after a long sleep. About 4 per cent. die, chiefly of pneumonia, heart failure or uræmic convulsions. In some patients the acute symptoms subside but leave some other alcoholic syndrome in their wake (*vide infra*). Relapses sometimes occur after some days of lucidity, and recurrences at intervals of months or years are extremely common.

Differential Diagnosis

Of the forms of excitement already discussed, only two are at all likely to be confused with delirium tremens, namely amentia agitata and paralytic delirium—themselves varieties of acute intoxication insanity. The following features of delirium tremens are useful in this connexion :

1. Predominance of visual hallucinations, usually of the characteristic type.

2. The slighter degree of clouding of consciousness, the mingling of true and false impressions.

3. Greater accessibility. The delirious paralytic if

sufficiently accessible, is divertible in mood and conduct, but cannot be awakened and caused to bring his mind to bear upon the actual *status quo*. The ament is inaccessible. Neither can be made to understand their situation or condition.

4. The completeness and frequency of the lucid intervals. In these, the alcoholic and the ament have a sense of illness, and an insight into their condition: the paralytic shows defective auto-criticism at all times.

5. Quite intelligible, though disconnected talking.

6. The gradual and characteristic onset.

7. The presence of signs of alcoholism, and absence of physical signs of G.P.I. or of severe bodily illness (when such is the case).

8. The preservation of the sense of personal identity, which is sometimes absent in the other two conditions, *e.g.*, the ament may think he is a spot on the wall, or a cloud; the paralytic, a god.

9. Much greater apprehension when at its worst, than ever occurs in paralytic delirium.

Treatment

The general management is the same in all confusional states. In the alcoholic form, it is advisable to give milk only, in order to spare the kidneys (often already functioning badly) as much work as possible. Stimulants, other than alcohol, should be used if required, especially strychnine and caffeine.

A brisk calomel purge at the onset, followed by a saline, should never be omitted.

These patients are sometimes prone to impulsive suicidal attempts, *e.g.*, they may jump out of a window to escape from hallucinatory terrors. If thwarted, and occasionally when not, they are violent.

To combat insomnia, chloralamide is useful in 20 grain doses, or amm. bromide grains 30 with a drachm or two of paraldehyde. They are best given at night, but may be ordered t.d. if required. A drachm or two of paraldehyde can always be administered a couple of hours afterwards if needed.

In all intoxication psychoses, more especially, it is better to dispense with sedatives altogether if possible, because the patient is already poisoned, and to substitute the continuous warm bath, aperients, etc., but unfortunately, this counsel of perfection is seldom practicable.

In any case, powerful poisons such as sulphonal, veronal, hyoscin, should be avoided, except as a last resort.

In general hospitals, hyoscine hypodermically may be necessary. If the heart is good, chloral hydrate combined with bromides and sal volatile and nux vomica, forms a useful mixture. It cannot perhaps be emphasized too often that delirium tremens patients are seriously ill, and yet eminently recoverable. Death in uncomplicated cases almost invariably indicates faulty management.

6. ALCOHOLIC PSEUDO-PARESIS

This condition is a form of alcoholic insanity allied to delirium tremens and resembling more or less closely in its symptomatology general paralysis. The duration is a few months and the termination complete recovery, a tendency to relapses, however, remaining as in the case of all recoverable alcoholic syndromes.

Symptoms

1. Sudden onset, usually after middle life.
2. Clouding of consciousness, with defective perception, and disorientation.

3. Incoherent speech.
4. Euphoria and expansive grandiose delusions.
5. Visual hallucinations, often of similar type to those of delirium tremens.
6. Physical signs of alcoholism.
7. Sometimes convulsions.
8. Rapid wasting.

This syndrome would appear to be another variety of amential episode occurring in the course of chronic alcoholism, one approximating more closely to classical amentia than does delirium tremens.

It is rare, and its diagnosis depends mainly on the question of physical signs and previous history, apart from which its resemblance to a transition phase between agitated amentia, and the paranoidal variety (*vide* p. 81) is occasionally very close.

Euphoria sufficient to result in grandiose delusions does not often occur in amentia, nor are the hallucinations predominately visual. The latter statement is also true of paralytic delirium.

With regard to physical signs, peripheral neuritis, and coarse tremors, when present, are indications of the alcoholic condition. Alcoholic tremors are more common in the upper, paralytic tremors in the lower part of the face. Rigid pupils are rare in alcoholism, common in G.P.I. Argyll-Robertson pupils and increased floppy knee jerks are conclusive evidence of the latter.

Nevertheless, the diagnosis is often only cleared up by the course. A positive Wassermann test in the cerebro-spinal fluid would, of course, be in favour of G.P.I. as at least 94 per cent. of paralytics manifest this.

Treatment

This should be carried out in the same manner as in the case of all acute confusional syndromes.

7. EPILEPTIC EXCITEMENT

Various forms of excitement occur in insane epileptics, and they have, of course, received different names. There is, however, no essential difference between any of them. They vary only in the depth of semi-consciousness present, and the prominence of some special feature or features. Excitement, motor, intellectual, or emotional, and some degree of confusion are exhibited in all.

For convenience in diagnosis, only two forms of excitement, differing from each other in the intensity of the symptoms, need be recognized. All chronic epileptics manifest certain features in common. These will appear as the varieties of clinical type of mental disorder are described, and may be found epitomized under the heading of epileptic dementia (p. 107).

(A) EPILEPTIC DELIRIUM

This syndrome resembles amentia agitata, and it is probable that in its production some share is taken by a process of intoxication. This theory is borne out by the relative rarity of delirium in patients already under treatment in an asylum, where the bowels, diet, etc., are attended to and no alcohol is obtainable. Almost all the cases seen are delirious on admission.

Diagnosis

The following are the chief points of distinction from amentia agitata.

1. In epileptic delirium :—
   (1) There is deeper stupefaction and clouding of consciousness with much more intelligible speech. The patient is evidently following a

train of thought, and gives expression to some links in the chain. There is no meaningless speech or disintegration of words.

(2) Mental processes are relatively slow and laboured instead of showing flight of ideas.

(3) Apprehension is deeper and more continuous.

(4) Hallucinations are more connected and terrifying, not so mutable and fragmentary.

(5) From the above, it will be apparent that the patient is less bewildered and confused than in amentia, but yet suffers from deeper imperception. His mind is less chaotic, but more cut off from the external world.

(6) Extreme blind violence prevails, alternating with periods of stupor of some minutes' duration. Probably the stupor is the equivalent of the lucid intervals of amentia.

Biting of those who approach is common.

(7) The duration is short—a few hours, or a day or two.

(8) There is no cachexia,

(9) nor, loss of the sense of personal identity.

Epileptic delirium may be excited by alcohol, and present features of delirium tremens. In such cases deep clouding of consciousness and inaccessibility, great violence with stuporose intervals, and the persistent absence of the semi-humorous mood, are the clues to the epileptic origin of the delirium.

Prognosis

Apart from injuries and accidents, the prognosis for the individual attacks is good. The patient emerges in a few hours, or at most a day or two. There is no danger to life.

Treatment

Shortly, the treatment is: Padded room, empty save for mattress and bedding, with an attendant or two at the door; 8 mimims of a 1 in 800 solution of hyoscin hypodermically and, if possible, a minim of croton oil by the mouth. (This may be embedded in a piece of butter.) The injection may be repeated in three hours if necessary.

Diet should be milk, if the patient will take it. If not, he may safely be left without food until he will feed himself. These patients are very dangerous, frequently homicidal, and sometimes suicidal.

(B) EPILEPTIC CONFUSION

This syndrome is an "equivalent," that is, a condition substituted for or associated with an epileptic convulsion, and being such, it is a more or less periodical episode with many insane epileptics. Under this heading are included epileptic "excitement" and epileptic "mania."

It presents much less clouding of consciousness than that last considered. The patient recognizes people he knows, and understands what is said to him. He is, however, confused about recent events, about time, and the general state of affairs around him. He is only rarely disorientated in a complete sense, so far as places are concerned, but he may only be able to say what sort of a place he is in. His memory for recent events shares the general confusion; he misconstrues things, and often "remembers" incidents that have not happened (pseudo-reminiscence). Occasionally hilarious and noisy, he is much more commonly angry or aggrieved, often imagining he has been, or is about to be, ill-used in various ways. These ideas not infrequently result in violence; at other times, the patient simply wanders aimlessly

about. Illusions are common, hallucinations only spasmodic, indeed, in many cases, absent altogether.

All mental processes, speech, and movement, are slow and stumbling. The hilarious cases show none of the exuberant gaiety of mania.

Prognosis

The duration of the attack is usually a few days, but in epileptics of long standing, and, the writer cannot help but think, in those kept continually on bromides, the confusion may persist for weeks.

Unless very prolonged, the patients seem none the worse for these equivalents.

Differential Diagnosis

Epileptic confusion is distinguished from the foregoing varieties of excitement, mainly by the slow impeded stumbling mentation. The patient's mental efforts suggest attempts at riding a bicycle whose pedals catch at intervals, and with the brake always partially on.

This impediment of thought manifests itself in the halting speech, slow reaction to questions, confused statements, and often in addition, a marked psychomotor difficulty becomes apparent in inco-ordinate articulation and movements. These features in conjunction with the absence of combinations of symptoms characteristic of the foregoing forms of excitement are sufficient to enable a differential diagnosis to be made.

Treatment

Briefly: Bed in a single room, slop diet, and a smart purge. It is desirable to avoid sedatives, but if this is

impossible owing to continued restlessness and insomnia, give chloral hydrate in doses of 20 to 30 grains b.d.

Bromides should be discontinued if the patient is taking them, as they only tend to intensify and prolong the confusion. Tact and kindliness of manner are very important to prevent explosions. (This remark applies equally well to all epileptic states where any degree of consciousness remains.) Ask and persuade epileptics, never order.

Complaints and charges of ill-treatment are frequently made by these patients. Let them see that all such are patiently investigated, and thus gain their confidence. Personal influence over epileptic patients is far more potent in maintaining good conduct and quietude, than all the drugs in the pharmacopœia.

8. STATES OF EXCITEMENT IN GROSS CEREBRAL DISEASE

This section is limited to the consideration of states of excitement occurring in cases of cerebral tumour, abscess, tuberculous masses, and meningitis.

The excitement is thought to be the result of intoxication by products of neural disintegration, or by causative bacterial toxins, and therefore related to amentia.

The majority of chronic cerebral lesions cause only progressive dulling, dementia, and physical signs.

There is no constant type of excitement peculiar to gross brain disease, nor can the variety or position of the pathological condition be determined from the clinical mental picture. But, and here is the important point, the excitement though simulating that of ordinary mental disorders, such as those already discussed, often lacks some features essential and displays some incongruous to those common forms.

It is only possible to give some illustrative cases.

Case I.—T. H., age 35, manifested genuine exaltation and buoyancy. He was continually restless, and talked in a confused unintelligible manner. Flight of ideas and disorientation were present, but individual perception was good. He understood what was said to him, and sometimes replied correctly to questions about his past life. Active attention was bad, passive quite fair. He was resistive, and kicked slyly at those who approached. He was obviously confused, and had no understanding of the general situation. Hallucinations were absent. Now this condition shows resemblances to only three of the disorders previously described, namely amentia, mania, or G.P.I. But obvious discrepancies are manifest.

Mania is excluded by the oppressive disorientation, meaningless speech, and marked confusion. Amentia by the lack of imperception, the quite good passive attention, the accessibility, the continuously cheerful mood, and the absence of hallucinations.

The liveliness of the excitement, the alertness, and rapidity of mental action, and the meaningless talk, taken in conjunction with the absence of expansive ideas, physical signs, and the general futility of the paralytic, prevent one from adopting a diagnosis of G.P.I.

By a process of exclusion upon these lines, the presence of some gross cerebral disease was considered the most probable solution. None of the ordinary physical signs of cerebral affections were apparent (optic neuritis could not be determined owing to the excitement of the patient), nor did the man at first appear physically ill.

During some weeks of continuous restlessness, he became gradually more unconscious, and finally comatose. Death occurred within thirty-six hours from the onset of the coma.

At the necropsy, tuberculous softening and destruction was found in the left cerebral hemisphere.

Case II.—This patient, a man of 29, was genuinely excited and exalted. He laughed and talked garrulously, was restless, struck absurd attitudes, and was transitorily negativistic and mute. Speech was incoherent, but intelligible and characterized occasionally by intrinsically ridiculous statements or verbigeration. Continual hallucinations of hearing took up a good deal of the patient's attention. Perception and comprehension of conversation were good. Degradation, moral perversion, obscenity and malicious acts, were absent. Marked anæmia and emaciation existed, apparently without any causative bodily condition.

This case looked very much like katatonic excitement, *i.e.*, dementia præcox. Here again, however, close observation revealed certain discrepancies. The excitement was too genuine, the restlessness too continued, and the general conduct too sensible and decent, and the hallucinations rather too obtrusive, also the marked physical illness had to be accounted for.

At the autopsy a tuberculous abscess was found in the anterior region of the left temporal lobe. In this case also no physical signs of gross brain disease could be made out during life.

Case III.—W. Y., aged 62, had been noisy and violent before admission. When admitted he was in a condition of continuous motor restlessness. He wandered about carrying his bedclothes, and paid no attention to his surroundings. He had no idea of time or place, but his comprehension of remarks and his active attention were good, and his mental re-action fairly rapid. He had apparently no memory, and manifested no particular emotional tone. The speech showed nothing abnormal. The physical examination nothing of importance, but

absent knee-jerks. The patient had, however, one or two mild epileptic fits daily.

Now this is not an easy case to diagnose. The first diagnosis thought was of epileptic confusion. But such a degree of dementia and amnesia would be accompanied by slow stumbling mentation, and the complete disorientation by a much deeper clouding of consciousness and inaccessibility. Moreover, no apprehensive, "wound up," resentful, or angry mood was present.

Such pronounced dementia in G.P.I. would be accompanied by physical signs.

Another solution that presented itself was a confusional episode in a rather premature case of senile dementia. Against this hypothesis are the continually recurring fits, the absence of signs of senility and arterio-sclerosis; moreover, good power of active attention, accompanied by complete general amnesia does not quite accord with this diagnosis.

As it transpired at the post-mortem examination, the patient had a sarcoma in his right cerebral hemisphere.

Prognosis

The outlook in cases of cerebral tumours, etc., is discussed in textbooks of medicine. The excitement in many cases only terminates with the onset of the coma that precedes death. A few cases exhibit remissions.

Diagnosis

The general method of diagnosis is indicated on the preceding pages, but the importance of a very thorough physical examination should be emphasized. The existence of combined psychoses (the most difficult question in clinical psychiatry) should be always borne in mind.

Apart from physical indications, these cases are often only elucidated by their course and results.

Treatment

The management of the excitement is identical with that suggested for acute confusional insanity.

9. STATES OF EXCITEMENT IN SENILE DEMENTIA

For convenience, and owing to the relative frequency with which they are found as separate entities, three clinical forms of excitement occurring in senile dementia may be described, but naturally, they merge into each other.

1. Maniacal excitement.
2. Confusional episodes.
3. Conditions resembling G.P.I.

1. The first condition is clinically mania plus senile mental impairment. Whether it is an expression of the manic-depressive diathesis, is due to abiotrophic and arteriopathic changes, or both, is doubtful. It is distinguished from mania occurring in normal, *i.e.*, undeteriorated old persons, by the presence of the demential symptoms (*vide* dementia senilis, p. 102).

2. Amential episodes must be regarded ætiologically as intoxication incidents occurring in the course of senile dementia.

In practice they have to be separated from amentia in sane old people. In the case of the dement the episodes show less agitation, apprehension, rapidity of mental action and fewer changes of mood, than uncomplicated amentia. Hallucinations are more sparse and may be absent. The patients are more accessible, and then, divertible. There may be no very definite emotional tone. The lucid intervals demonstrate the dementia.

As noted under the last section (Case III) amential episodes in arteriopathic and abiotrophic cases may resemble other organic brain lesions. The attacks are usually of only a few days' duration.

3. This form is characterized by marked dementia, and amnesia, euphoria, absurd grandiose delusions, and motor restlessness.

It differs from G.P.I. chiefly in the following features:

(*a*) The age of the patient.

(*b*) The presence of a degree of dementia only compatible in G.P.I. with advanced physical signs and cachexia.

(*c*) The lively emotional state, more active and quicker mentation, and better passive attention.

Treatment of Senile Excitement

Apart from tube feeding, which is practically never required in these cases, the treatment is the same as that recommended for amentia. Owing to the feebleness of the patients and their frequent habit of crawling about, padded floors are desirable in their single rooms. If these are not available mattresses should be placed on the floor to cover it completely.

10. STATES OF EXCITEMENT DUE TO DRUGS

Certain poisons produce delirious states (resembling amentia) in one of two ways; either as the result of acute poisoning or as an abstinence symptom. Examples of drugs of the former class are Cannabis indica and belladonna, and the delirium is distinguished by the physical signs produced by the poison from which it arises. The commonest toxins producing acute confusion as the result

of abstinence are as follows : alcohol (already discussed), morphia, cocaine, chloral. In the last three, the physical signs present in the delirium are such as would be produced by a perfect antidote to the respective drugs. In fact, the condition is regarded as due to an excess of anti-bodies in the blood.

Morphinism not infrequently produces a more or less lucid delirium with marked visual hallucinations and systematized delusions of persecution, accompanied by irritable, aggressive, or dangerous mood.

For the physical signs of poisonings and their medical treatment other works must be consulted. The management of the excitement is similar to that of amentia.

Few cases are admitted without a clear history of drug habit. The frequency of the co-existence of morphinism, cocainism, and alcoholism should be borne in mind.

CHAPTER II

STATES OF DEPRESSION

1. MELANCHOLIA

MELANCHOLIA is more or less widely considered as a phase of manic depressive insanity. It may recur as such, may alternate with mania, with or without normal periods between, or be combined with it; and finally, melancholia quite commonly occurs as an isolated attack once in a lifetime. *A priori*, one would presume the absence of any particular diathesis or temperament in the case of single attacks, and this is borne out by previous knowledge of the patient and by the existence of conspicuous external cause.

Definite exciting causes are more common in the case of melancholia than mania, and the duration of the attack is usually longer. The essential feature of melancholia is misery from inadequate existing external causes. The depth of the unhappiness varies in different cases, from simple depression of spirits to shrieking anguish.

In some cases the disease becomes chronic, and in these the power of feeling grows so blunted that scarcely any emotion at all is experienced. Such patients often retain some special unpleasant delusion which they cherish, and apparently almost take a pleasure in.

Melancholics are so absorbed by their mental pain

that they are impervious to pleasant sensations or thoughts, and often to real external causes of distress. They are lucid, well orientated, have good comprehension and memory. There is one exception to this rule ; some cases suffer from very vivid irrepressible ideas and impulses (*e.g.*, to suicide, mutilation) which may at times result in sudden violent action. In this state (termed raptus) the patient is so engrossed in his idea that he is practically unconscious of all else.

Apart from raptus, clouding of consciousness occurring in melancholia must be regarded as an exhaustion (*i.e.*, intoxication) symptom ; so also must any degree of confusion, or hallucinations. These symptoms do not occur in uncomplicated melancholia.

Another important feature of melancholia is paresis or impediment of volition. This is always present during some part of the attack, and often throughout the course until the patient begins to recover. The result is indecision, difficulty in doing anything, slow action, speech, and re-action to stimuli ; the patient having to make an obvious effort to overcome the obstruction. In some cases, this impediment of will produces definite stupor (*vide* Stupors, p. 86).

Many melancholics develop delusions, unpleasant or fearful, and always self-depreciatory. These erroneous ideas are never intrinsically impossible, but often outside the bounds of possibility under the existing circumstances. Various absurdities are described by patients as seeming so, but they know such are not really the case.

The commonest delusions are of sin, ruin, damnation, injury to relatives, present illness, and impending death. Insomnia is constant in acute melancholia, and constipation the rule.

Some melancholics, especially senile cases, appear more irritable than obviously unhappy. Many are resistive

to all interference. This obstinacy must not be confused with true negativism (*vide* Glossary), which does not occur in melancholia. Persons suffering physical pain frequently resent any interference, *à fortiori*, those suffering mental pain. The resistance in its conception is logical.

The symptoms of melancholia then may be briefly summarized as follows :—

1. Genuine misery, without adequate external cause.
2. Self-depreciation.
3. Slow painful ideation, often concerned with some special train of thought, from which the mind can only be transitorily diverted.
4. Impediment of will.
5. Delusions, if present, depressing, self-depreciatory, unchangeable by argument, and within the bounds of possibility.
6. Collectedness and good memory.
7. Reasonable conduct, the logical outcome of the thoughts and feelings (due allowance being made for volitional paresis).
8. Insomnia, in recent cases.

Prognosis

The outlook in a recent case of melancholia is good. About half of these patients recover completely, and a fair proportion of the remainder, though slightly impaired in mental action and emotional sensibility, get well enough to return home.

Cases under middle age are more likely to recover, but more prone to recur. Very short attacks also tend to recur. A duration of three years is not incompatible with ultimate recovery.

Treatment

In acute cases more or less marked debility accompanies the depression. These patients must be kept in bed.

When the case is admitted, it is well to give enemata until the bowels act, and then a calomel purge. Afterwards, the patient should be kept on some aperient mixture regularly. The diet at first should be light and fattening, *e.g.*, milk, eggs, meat juices, etc.

As the acute stage passes off, the patient must be fed more liberally until he is on full diet in addition to milk and other extras. As all melancholics are potential suicides, only spoons should be allowed them until their individual tendencies are known. A certain proportion of melancholics refuse food. They can, however, often be induced to eat by firm persuasion or spoon-feeding by an attendant. Others have to be fed by the stomach tube, but there is not the urgency for its use that exists in the case of amentia.

The drugs most useful in the treatment of melancholia are opium, paraldehyde, and in cases with high blood-pressure, nitrites. Tr. Opii Ms. x to xxx combined with Mag. Sulph. and Nux Vomica, has sometimes proved valuable.

For insomnia a drachm or two of paraldehyde can be given in addition. Intestinal antiseptics are recommended, but the writer has seen no better results from these than from simple purgation. Calomel in small doses, *e.g.* $\frac{1}{4}$ gr. t.d.s., serves both purposes.

After the subsidence of the acute stage, tonics such as Easton's Syrup may be given ; the casein and glycerophosphate foods are useful from the beginning.

Sour milk preparations can at least do no harm, provided the bowels are kept active, and they make a change for the patient.

Cases of prolonged raptus and those with exhaustion symptoms must be treated as amentia.

Owing to the impediment of will beginning later and disappearing before the depression of spirits, melancholics are more prone to commit suicide at the beginning and at the end of their attack; so early discharge from the asylum, or the cessation of careful observation at home, should be discountenanced.

Differential Diagnosis

Of the preceding conditions amentia is the only one with which melancholia as described here can be confused.

In ordinary severe forms of agitated melancholia, the absence of hallucinations, imperception, flight of ideas, disorientation, etc., distinguish it at once from amentia agitata. In melancholia with exhaustion (*i.e.*, intoxication symptoms) the diagnosis is not so obvious. The difference lies mainly in the melancholic's continuous mood of depression, his much less rapid ideation, and the slighter degree of clouding of consciousness. Many of these latter cases are stuporose and resemble amentia attonita (*vide* Stupors, p. 89).

In severe cases of raptus, melancholics may shriek, lacerate themselves, pull out their hair, etc., continuously for weeks, and are apparently unconscious of their surroundings. Some also exhibit hallucinations (exhaustion). Here again, the unchanging mood, and the absence of flight of ideas, are the chief distinctions from amentia; moreover, most of these patients can by insistence be made to reply sensibly, if briefly, to a question, although they return at once to their self-engrossed state of misery; thus showing that their consciousness is not so clouded as it appears.

2. STATES OF DEPRESSION IN DEMENTIA PRÆCOX

A period of depression resembling melancholia frequently occurs at the onset of dementia præcox, and short, less accentuated attacks, are often scattered throughout the earlier part of its course. The latter usually take the form of transitory bouts of weeping, etc., of no clinical significance.

Symptoms

The following are the chief features of the well marked attacks of depression :—

1. Misery that is more apparent than real, either with some motor unrest or of quiet variety, more frequently the latter. The apparent insincerity of the unhappiness is due to the fundamental emotional dullness of dementia præcox. This is shown by a certain theatrical display of misery, by exaggerated expression, and occasional vacant smile or laugh, or by a temporary spell of cheerfulness.
2. Seclusiveness often, in quiet types.
3. Hallucinations commonly, especially of hearing.
4. Absence of desire for action, not always easily distinguished from the melancholic's impediment of will, the results being much the same.
5. Some indications of katatonia. These are not by any means constant, but illogical conduct, purposeless movements and gesticulations, affected mannerisms, negativism, may be noted at intervals in some cases. Abnormalities of speech are commoner, *e. g.* occasional irrelevant meaningless or silly remarks, more rarely echolalia, verbigeration or neologisms are encountered (*vide* Glossary).

Some cases rapidly develop katatonic stupor (*q.v.*).

6. Delusions are generally present, often persecutory, hypochondriacal, or intrinsically absurd.

7. Collectedness and good memory.

8. The "self-puzzled" state common in all early manifestations of dementia præcox (*vide* p. 90).

Differential Diagnosis

In the majority of cases some of the special dementia præcox symptoms mentioned above, will at once distinguish depression in that affection from melancholia. In those in which these signs do not at once display themselves, the insincerity of the woe usually elucidates the diagnosis. Moreover, impediment of will and sincere self-depreciation are absent in dementia præcox.

It must be confessed however, that in practice some of the initial cases of depression are exceedingly difficult to distinguish from melancholia.

Prognosis

A small minority of cases apparently recover, and of these some become insane again, and finally demented. A few others remain seclusive and apathetic, but are fit to be at large. About 80 per cent. grow progressively demented. Cases without katatonia are of most favourable prognosis.

Treatment

This is on the same lines as for melancholia. These cases often possess strong tendencies to suicide, in order to escape from persecution, or in response to "voices." As they suffer from no impediment of will, their attempts are often sudden, thorough and determined, and incidentally bizarre.

3. STATES OF DEPRESSION IN GENERAL PARALYSIS

A state of depression may usher in G.P.I. and persist more or less throughout its course, or give place after a short time to other phases of the disease.

The melancholic condition may be of a quiet dull variety or be accompanied by motor unrest and noisy lamentations.

Differential Diagnosis

(A) From Melancholia :

1. The following features are present in G.P.I., but absent in melancholia :
   (*a*) Distress that is shallow and superficial owing to the all round dulling of the faculties, both emotional and intellectual, characteristic of G.P.I.
   (*b*) Evidence of exaltation of the ego ; in speech, conduct, etc.
   (*c*) Delusions (often intrinsically impossible) manifesting the same, *e. g.*, persecutions by great persons, or by large numbers of people. Hypochondriacal ideas often show a similar undercurrent, *e. g.*, that the bowels are blocked by gold.
   (*d*) Flashes of euphoria and temporary grandiose ideas, generally at night, are not uncommonly seen.
   (*e*) Occasional attacks of confusion (not very frequent in this phase of G.P.I.)
   (*f*) Some degree of intellectual deterioration, *e. g.*, impaired memory, attention, perception, and inability to do simple sums.

(*g*) Volitional feebleness and divertibility. One may sometimes make a paralytic who thinks he is dying and eternally damned, smile or laugh and talk of other matters.
(*h*) Physical signs of G.P.I.

2. In G.P.I. the following do not occur:
(*a*) Deep misery.
(*b*) Self-depreciation and altruistic despair.
(*c*) Impediment of will.
(*d*) Insight into personal condition; often present in melancholia.

(B) From Depression in Dementia Praecox:

There is in some of the later forms of the above disease no little resemblance to G.P.I. Stress should be laid on the following points:

1. Present in G.P.I.:
(*a*) Shallow, but sincere depression.
(*b*) Defects of memory, perception and passive attention.
(*c*) Volitional feebleness and divertibility.
(*d*) Transitory euphoria and expansive delusions.
(*e*) Physical signs.

2. Absent in paralytic depression:
(*a*) Pedantry and affectation.
(*b*) Katatonia, including negativism.
(*c*) Meaningless remarks, echolalia, neologisms.
(*d*) Purposeless conduct (apart from confusional episodes).
(*e*) Hallucinations of hearing and sight, in the majority of cases.

4. THE DEPRESSION OF INVOLUTION AND SENILITY

Three main clinical types of depression present themselves at the onset, or during the progress of involution. Perhaps their chief interest lies in the ætiology, a discussion concerning which cannot be entered upon here.

1. The first variety is indistinguishable from melancholia, and should possibly be regarded as an expression of the manic-depressive diathesis. A history of former phases is sometimes forthcoming.

2. True involutional depression (that to which Kræpelin has arbitrarily restricted the term melancholia) characterized by restless misery of a lucid type, manifesting no impediment of will, slowing of ideation, or mental deterioration.

It usually occurs at the onset of involution, and is possibly merely an exaggeration of the physiological depression of that period, analogous to the exaggeration of the normal *bien d'être* of puberty that sometimes occurs.

Delusions, however, may be present, though these are generally more of the nature of magnifications of actual causes of unhappiness, than baseless erroneous ideas.

In these cases, there is no history of previous attack.

3. Senile depression occurs later physiologically. It differs from melancholia in the following respects :—

(1) In the presence of symptoms due to the egotism of old age, viz. :

(*a*) Absence of deep self-depreciation.

(*b*) Absence of altruistic depression.

(*c*) Frequency of delusions of apprehensive nature, of personal injury and persecution, or hypochrondriacal notions.

(2) In the presence of signs of intellectual impairment :

(*a*) Feeble volition and divertibility.

(*b*) Loss of power to retain recent impressions and other mnemonic defects (*vide* Dementia senilis, p. 102).

(*c*) The occurrence in some cases of short periods of exaltation or confusion.

Impediment of will is absent in these cases.

They should probably be regarded as a depressed phase of senile dementia.

Treatment

The treatment of these depressed states occurring in the involutionary period does not differ from that of melancholia, except that allowance must be made on medical grounds for the age of the patient, *e. g.*, in the administration of sedatives.

Prognosis

1. Melancholia at this period of life lasts longer than in younger folks, and some emotional dulling commonly remains.

2. Kræpelin's melancholia runs much the same course as other melancholic attacks, and recovery is equally probable.

3. Senile depression terminates in dementia of senile type. The depression usually passes off as the dementia progresses.

5. EPILEPTIC DEPRESSION

Depression in epileptics is an equivalent (an incident analogous to a fit) and hence such attacks are more or less periodical, frequent, sudden, short (not more than a

day or two), similar, and without external cause. It sometimes precedes or follows convulsions, more frequently the former.

The depression is of a quiet nature, not as a rule accompanied by definite delusions, but often by somatic sensations and ideas of bodily illness, or by fancies of persecution, insult, or neglect, based upon misconstruction of the conduct of others.

The usual epileptic "wound up" temper and irritability are present, and sometimes a slight degree of confusion. The egotistical self-esteem, sensitiveness, slow clumsy mentation, and external religiosity of the chronic epileptic in all his phases, will also be apparent.

The above points are amply sufficient to distinguish this form of depression from every other. It will be observed that it borders upon epileptic confusion, and of course the distinction is arbitrary,—only a matter of the relative prominence of the respective denominating symptoms.

Treatment

No treatment is required, except an aperient. Tact and sympathy, together with the assurance that the (imaginary) ailment will be watched by the doctor, and treated, if necessary, and the (imaginary) grievances investigated—which by the way, should be done—are all that is necessary. In some cases, where one has gained the patient's confidence, one can explain to him with benefit that his morbid feelings are substituted for a fit and that nothing else is really amiss.

CHAPTER III

DELUSIONAL STATES

1. PARANOIA

PARANOIA is a delusional condition, sometimes regarded as an atavistic anomaly. It is of gradual development and exerts no influence upon the bodily health. There is reason for thinking that at bottom it is a disorder or perversion of instincts common to all men; *i. e.*, of the subconscious ego. The psycho-analysts regard it of course as of sexual origin and attribute it to repressed homosexuality.

The development of delusions in persons of paranoical temperament is an extremely likely, but not necessary contingency. Some cases never develop delusions at all, others need the aid of a psychosis, or stress of circumstances to bring the development to pass. The conduct of delusional paranoiacs usually brings them into conflict with their environment between the ages of 40 and 60. It is then necessary to confine them in some sort of institution. The mental family history of paranoiacs is almost invariably bad.

When the delusions are fully matured paranoiacs present the following characters :—

1. A coherent delusional view of life into which all events are fitted by a process of misinterpretation and illusion, and past incidents dovetailed by means of pseudo-reminiscence (imaginary memory). The ever widening

edifice of this delusionary structure is built up upon the false basis of an inherent pre-conception, and is permanent, fixed and unalterable by argument. The delusional content may be :—

(*a*) Abstract and apparently altruistic, *e. g.*, propaganda of impracticable schemes and theories. Such paranoiacs are called "Mattoids."

(*b*) Ego-centric :

(i) Persecutory. (ii) Ambitious. (iii) Querulant (persecuted persecutors). (iv) Erotic. (v) Hypochondriacal.

In many cases these varieties tend to merge into each other as years go on, and they are all present in embryo in all paranoiacs. The delusions are never intrinsically impossible under every conceivable combination of circumstances.

2. A normal emotional state and reaction, except for exaggerated self-esteem and "touchiness."

3. Logical conduct, and dignified bearing.

4. Lucid unimpaired, often powerful intelligence and memory, except for the warped judgment and pseudo-reminiscence in connexion with the delusions. Active mentation, untiring energy and power of application.

5. Strong volition and absolute undivertibility.

6. Very occasional hallucinations. Some ambitious paranoiacs under great stress of emotion enjoy (used advisedly) hallucinations, just as hysterical individuals may.

A few deliberately invent them, but afterwards come to believe their own fabrications.

Prognosis

Paranoiacs cannot lose their delusionary outlook upon life, any more than normal persons can change their

temperaments. For it is the temperament that is essential to the development of the delusions of paranoia.

A few cases, however, decide not to allow their views to exercise much influence upon their conduct; especially when they find such self-denial saves them from an asylum.

There is no tendency to dementia, but persons of paranoical temperament are susceptible to attacks of psychoses.

Treatment

There is of course none. Those persons who are a danger or a nuisance to other people must be confined somewhere, and an asylum, though essentially unsuitable, seems to be the only place available.

In dealing with paranoiacs, it is useless pretending to them that they are ill; they are only irritated thereby. They should be treated on a footing of polite equality, and persuaded to occupy themselves usefully in the asylum. It is better to ignore their delusions.

Their conduct is usually exemplary, but if they are a source of annoyance to other patients, it should be quietly explained to them that their ideas are their own ("we must agree to differ"), but they must not do anything to disturb the harmonious working of the asylum. They usually see the force of such arguments.

Some further notes on the paranoical temperament will be found under the heading of Border-line cases (p. 123).

2. PERSECUTORY HYPOCHONDRIA

An affection of delusional nature occurring at about the menopause in women and at an analogous period of life in men. The condition is usually described as one of the varieties of dementia præcox. (What is not?)

It is treated here as a separate condition, for reasons that will appear from the subjoined symptoms, course,

and termination. It should be borne in mind, however, that some paranoid forms of dementia præcox in the early stages, manifest delusions similar in content. Persecutory Hypochondria should probably be regarded as an involution delusional insanity, and possibly its resemblances to dementia præcox—the developmental insanity par excellence—are due to the existence of some disorder of sexual metabolism in both.

The distinctions from dementia paranoides, *i. e.*, the paranoid forms of dementia præcox (*vide* p. 66), are as follows :—

1. Persecutory hypochondria as described here does not present the fundamental feature of dementia præcox, viz.—"Failure of every impulse to energy. Loss of mental activity and interest in particular, emotional dullness and absence of independent impulses of will." (*Kræpelin.*) "Affective vacuity, stolidity of conduct. The will does not act under the influence of motives, but from organic stimuli, which have no psychical correlative." (*Tanzi.*)

2. It does not terminate in incoherent dementia.

3. Katatonia, negativism, "mannerisms," automatic obedience, purposeless acts, illogical conduct, moral degradation, and the abnormalities of speech—characteristic of dementia præcox,—form no part of its symptomatology.

4. The type of delusion remains unalterable and fixed, viz : bodily molestation, and the individual content fairly coherent and simple to the end.

5. The onset occurs after the age of forty.

Symptoms of Persecutory Hypochondria

1. Unshakeable delusions of persecution of the nature of physical injury or interference by some unseen agencies

or persons, *e. g.*, by electricity, hydraulic power, etc., and these attacks may be attributed by the patient to definite living people.

The exact description of the persecution given by the patient is probably governed by hallucinations, and may vary from time to time, but the type remains unchanged.

2. Hallucinations, especially of hearing (voices, etc.) and of bodily sensation.

3. A mood of excitability and resentment against persecution, developing at times into definite depression or angry excitement. These emotional disturbances are sincere, and do not display the impress of basic apathy.

4. Collectedness and rationality apart from the delusions, with active mentation and good memory.

5. Normal speech, except for occasional neologisms (such as occur even in paranoia) to explain the mode of persecution.

6. Logical and decent conduct.

7. Remissions, during which there is freedom from hallucinations, almost normal emotional tone and conduct, and as far as can be ascertained, absence of delusion. Many patients, if not all, at such times enjoy an insight into their past condition and recognize that the hallucinations and delusions were of morbid origin. These remissions may endure for several weeks, or even longer.

8. A definite onset which may be more or less abrupt and coloured by excitement, depression or confusion.

Prognosis

The ultimate prognosis is hopeless. These patients, apart from remissions, remain unchanged for years, and finally become weak-minded and senile.

Treatment

There is at present no known treatment of any avail. Suicidal and violent tendencies are not uncommon, although in asylums the patients for the most part behave well and make useful workers, except when upset too much by their hallucinations.

Differential Diagnosis

The main points to bear in mind in distinguishing this condition from paranoia, are as follows :—

1. The absence in persecutory hypochondria of the systematized delusionary view of life, resulting from the piecing together of disconnected incidents spread over years.
2. The absence in paranoia of chronic hallucinations.
3. The existence of an onset and the occurrence of remissions in persecutory hypochondria.

3. DEMENTIA PARANOIDES

The varieties of dementia præcox, namely hebephrenia, katatonia, and the paranoid form now to be considered, merge into each other and rarely occur pure. The paranoid form is merely characterized by the prominence of delusions, in some cases by a more chronic course, and usually a later onset.

Symptoms

The main features of a typical case are as follows :—

1. Delusions—fantastic, absurd, ever changing, and increasing in number. They are apt to be persecutory at first (*e. g.*, unseen influences, mesmerism, injury by hidden machines, reading of the patient's thoughts, etc.)

and grandiose later. This is the usual tendency of delusions accompanied by progressive dementia, as these are: only in the early persecuted stages do the delusions affect the conduct to any great extent.

2. Chronic hallucinations, chiefly "voices."

Pseudo-hallucinations (*vide* Glossary) are peculiar to dementia præcox, and this one symptom when present with delusions is sufficient to enable one to make a diagnosis of that affection.

3. The basic apathy, emotional dullness, and absence of interest—of dementia præcox.

4. Some degree of katatonia or catalepsy, *e. g.*, negativism, automatic obedience, mannerisms, etc.—not common in early stages.

5. Motiveless conduct (this statement does not, of course, mean that every action of the precocious dement is motiveless).

6. Pedantic, affected, stereotyped or occasional meaningless speech.

7. Good memory, comprehension and orientation.

8. Onset, often with an attack of depression, excitement, or confusion.

9. Termination in incoherent dementia, within six months to five years of the onset.

Prognosis

None of these cases recover.

Treatment

This is confined to general care and management. In the early stages there are tendencies to suicide and dangerous violence. Except in the final stage all cases of dementia præcox are prone to impulsive and purposeless acts.

Differential Diagnosis

The distinctions in well developed cases from paranoia are too obvious to call for special mention; those from persecutory hypochondria have already been given (p. 64).

Early cases of dementia paranoides not infrequently manifest no obvious features of dementia præcox, but simply present a picture of recent, but more or less systematized delusions of persecution, perhaps mingled with ideas of self-importance. Slight pedantry and an occasional peculiarly twisted remark, the age of the patient, and above all pseudo-hallucinations, give the key to diagnosis.

4. SENILE DELUSIONAL INSANITY

This condition exhibits more of the nature of an independent syndrome than any other of the senile psychoses. It cannot be regarded merely as a phase of senile dementia, although dementia is both its termination and partly responsible for its clinical signs.

The onset is sometimes coloured by depression or excitement.

Symptoms

In all essentials the clinical picture and course are identical with those of persecutory hypochondria. The divergences from the latter are here set down:—

1. Some cases manifest more varied delusions, occasionally associated with ideas of euphoric character, or jealousy of wife's fidelity.

2. A somewhat more placid, and at times exalted mood, but one still excitable and irascible.

3. A certain degree of intellectual enfeeblement (not of senile type with loss of power to retain recent impressions and impairment of the power of attention, but a narrowing of the field of ideation, a certain poverty of thoughts and interests, and defective memory for general and remote events). Nevertheless within its limits ideation and mental action generally is active enough.

It will be seen that these distinctions from persecutory hypochondria are merely due to the super-added dementia. Grandiose ideas in delusional psychoses are indications of mental dissolution. The delusion of jealousy is common in senile cases and in alcoholics, probably as the result of some real or imaginary (cœnesthetic) disability in connexion with the sexual act. The more placid mood is due to affective blunting, accompanying the general impairment.

We must, therefore, probably regard these cases of senile delusional insanity as persecutory hypochondria of delayed onset. The ætiology of the slight impairment of intellect present in the disease is uncertain. In point of fact, without the aid of the history of the case, types which arise in old people cannot be distinguished from cases of persecutory hypochondria which have grown old in the disease and the asylum.

5. ACUTE HALLUCINATORY DELUSIONS

("ALCOHOLIC MANIA")

This affection, like delirium tremens, is a psychosis of chronic alcoholics. It merges through various transitional states of confusion, into the definite clinical picture of that disease, by which it is sometimes preceded. It differs in its typical form from delirium tremens in the absence of clouding of consciousness, imperception, and disorientation (in short, it is not a delirious state), and

also in the prominence of delusions and auditory hallucinations.

Symptoms

1. Extravagant incoherent delusions of persecution.
2. Prominent auditory hallucinations; chiefly voices uttering terrifying threats and accusations. A few visual hallucinations not infrequently occur in the initial stage.
3. An emotional tone for the most part of anxiety and apprehension, but showing at times a half-humorous colouring.
4. Divertibility in mood, thought, and conduct.
5. Some degree of motor restlessness with insomnia.
6. Good orientation, perception, comprehension of conversation, and memory.
7. A sense of illness, and at times, an insight into the condition.
8. Sometimes physical indications of alcoholism.

Prognosis

The prospect of recovery is usually good: the syndrome passing off within a few months. The usual alcoholic tendency to relapse remains, and occasionally the affection becomes chronic in the form of the next condition to be described.

Treatment

These cases are sometimes suicidal and violent in the more acute stages. In an asylum they are usually no trouble, though often restless at night. They can be persuaded, at any rate for the time, that their hallucinations are the fancies of a disordered mind, and are calmed and comforted thereby. The only treatment needed is

purgation, a strychnine tonic, and a couple of drachms of paraldehyde or 30 grns. of Ammon. Bromide s.o.s.

Differential Diagnosis

The distinctions from delirium tremens have already been given. The diagnosis from persecutory hypochondria is based upon the following points in the alcoholic condition :—

(*a*) The incoherent changeable delusions.

(*b*) The frequency and terrifying nature of the hallucinations.

(*c*) The more marked emotional disturbance, showing considerable apprehension alternating with frightened jocularity.

(*d*) The divertibility and suggestibility.

(*e*) The sense of illness.

The divergencies from dementia paranoides are obvious, *e. g* :—*b*, *c*, *d*, *e*, above, and the absence of the special symptoms of dementia præcox, viz : basic apathy, katatonia, speech abnormalities, etc.

The diagnosis from the confusional psychoses previously described is equally apparent, *i. e.*, there is no delirium and no continual motor excitement.

6. CHRONIC HALLUCINATORY DELUSIONS

This psychosis may follow attacks of delirium tremens or the last discussed syndrome, or some intermediate alcoholic confusional state. It is simply an attenuated and chronic form of alcoholic " mania " with symptoms of intellectual deterioration super-added, *e. g.*, all autocriticism is lost.

The delusional content is apt to be single in the later stages (influenced by the chronic auditory hallucinations,

which are accusing, mocking, threatening or inciting, *e. g.*, commonly to indecent acts), and the erroneous ideas fantastic, numerous and mixed in the earlier stage, often showing a mingling of exaltation and a sense of persecution.

The emotional tone is more humorous and less apprehensive than is the case in the acute form; childish hilarity is sometimes apparent. The moods are more unstable and mutable; divertibility is well marked in mood, but very much less so in thought; indeed, the delusions are for the most part fixed.

Alcoholic intellectual enfeeblement manifests itself eventually in poverty of thought, loss of wider interests, and mnemonic defects (*vide* p. 112), and immediately, in the impairment of judgment noted above.

With regard to the prevailing emotional tone; in some cases seen—probably transition stages between the apprehensive acute forms and the more jovial chronic forms—the still existing apprehension is accompanied by depression of melancholic morose type, which gives a superficial colouring to the case occasionally liable to be misleading. Examination always reveals the semi-humorous mood.

Prognosis

This is hopeless, but the progress of the dementia is very slow.

Treatment

No treatment is of any avail. Many of these patients are excellent asylum workers. In spite of the nature of the hallucinations their conduct is good, and they are distressed at the suggestion of immorality thus, as they imagine, received.

Differential Diagnosis

Of the preceding conditions, the one which is most likely to be mistaken for the present is persecutory hypochondria. The distinction is based upon the presence in the alcoholic syndrome of :—

1. The semi-humorous mood, and its instability.
2. The divertibility and weakness of will.
3. The indications of intellectual and moral alcoholic impairment (when present).
4. Upon the absence of the chronic simple and typical delusions of persecutory hypochondria.
5. And the predominance of hallucinations.
6. The history.
7. The hang-dog coarsened appearance of the chronic alcoholic, and perhaps other physical signs.

Those cases in which fantastic and exalted delusions are conspicuous, and especially if they are mingled with persecutory ideas, bear no inconsiderable resemblance to general paralysis. This is the more true if the hallucinations are temporarily in abeyance, and the mood hilarious and exalted. Moreover, there is not a little of the general air of futility of the paralytic manifest in some of these patients. The absence of physical signs of G.P.I. enables a diagnosis to be made, but apart from these other useful points of distinction are as follows :—Auditory hallucinations apart from confusional episodes do not occur in G.P.I. The memory for times and dates in the alcoholic condition is relatively unimpaired and the ability to do simple sums (if ever present) is retained. The mental action generally is quicker and more active than would be the case in a paralytic who manifested such fantastic delusions as do these alcoholics. The delusions are also in some cases added to, by a process of endless pseudo-reminiscence on the part of the alcoholic.

7. ALCOHOLIC "PARANOIA"

The so-called alcoholic paranoia is another of the psychoses of chronic alcoholism. In its typical form, with more or less systematized delusions of persecution or grandeur, it is rare. And it is not unlikely that such cases are dependent in part upon a paranoical temperament in the patient.

The more common form presents the following:—

Symptoms

1. Delusions; possible in content, usually few, and almost invariably based upon the idea of infidelity, depravity, robbery, on the part of some relation, friend or acquaintance. Conjugal infidelity is by far the commonest idea.

2. Misconstruction of events connected with the objects of the delusion, to reinforce them.

3. A mood dangerous, angry, or resentful, yet becoming at times semi-humorous. But in an asylum the emotional tone is for the most part normal. The departures from the normal mood are logical given the truth of the delusion, and neither in excess nor abnormally insignificant.

4. Complete collectedness, with good understanding of the general situation.

5. Absent or only very occasional hallucinations, except at the onset, which may be marked by some acute alcoholic syndrome.

6. Symptoms of alcoholic intellectual and moral impairment, *e. g.*, poverty of thought, circumscribed mental outlook, defects of memory (especially for recent events) and of power of attention, irritability, selfishness, lying, brutalization of conduct.

7. Physical signs of chronic alcoholism, *e. g.*, coarse tremors of fingers and tongue, increased or absent knee-

jerks, peripheral neuritis, slurred speech. The absence of these signs is of no significance. The characteristic facial appearance and demeanour.

Prognosis

The prognosis is bad. Some cases lose their delusions after a short time in the asylum, but almost invariably relapse when discharged. About an equal number make no improvement, but remain unchanged for many years, finally and gradually becoming definitely weak-minded.

Treatment

Treatment simply consists in the suggestion of the idea of abstinence from alcohol, and confinement in an asylum. In most cases permanent detention is desirable, but, when the delusions disappear, impossible under existing conditions. Prior to admission, these cases are often brutal in conduct and ill-use and occasionally kill their spouses, but as asylum patients, being blustering but cowardly bullies, they are usually well behaved.

Differential Diagnosis

(A) From Paranoia :—

In the alcoholic condition as here considered, the delusions are not continually growing and widening by a process of misconstruction of unconnected events into a systematised delusionary outlook upon life. The symptoms of deterioration enumerated in (6) on the previous page do not occur in paranoia, which, moreover, has no definite onset nor semi-humorous mood.

(B) From Persecutory Hypochondria :—

The different type of delusion, the absence of prominent hallucinations, the alcoholic mood and emotional re-

action, the symptoms of mental and moral and physical impairment, taken together, sufficiently separate the two conditions.

8. DELUSIONAL STATES IN G.P.I.

The majority of general paralytics manifest delusions, which in many cases are predominant during some phase of the disease. The delusional states take many forms and merge on the one hand into depression, and on the other into excitement, while, as is the case in all the syndromes of G.P.I., a steady mental deterioration coexists throughout.

Two main varieties may be described :—

(A) Those dependent upon euphoria.

(B) Those dependent upon feelings of disability.

Then, again, the combination of these two cœnesthetic states is common in general paralysis.

The first form comprises the classical megalomaniacal or expansive group.

The second division embraces two classes of syndromes :—

1. Hypochondriacal and persecutory forms.
2. Paranoidal varieties.

(A) THE EXPANSIVE FORMS

The megomaniacal excitement has been described in Chapter I. Here it is necessary to consider a condition in which excitement is inconspicuous and expansive delusions prominent.

Symptoms

1. Delusions of grandeur, wealth, or vast ability, accompanied by glowing hopes and exaggerated impossible plans. These erroneous ideas are for the most part disconnected and changeable, but unshaken by con-

tradiction. The indication of their impossibility merely results in amplifications and the advancement of absurd arguments and explanations in their support. (This is the meaning of the term expansive delusions.)

Except in the early stages, the delusions exert little influence upon the patient's reaction to his environment.

2. Relative emotional dullness. The delusions, absurd as they are, are often stated with indifference although a certain boastfulness of manner may be present.

3. Volitional feebleness, and divertibility of mood and conduct.

4. Intellectual impairment, shown by defects of memory, acuity of perception, attention, interest, and mental activity generally, of varying degrees up to definite dementia (*vide* p. 98).

5. Physical signs of G.P.I.

Differential Diagnosis

This phase of the disease is not likely to be mistaken for anything else, but certain other conditions may require careful observation to distinguish them from it.

1. The excited phases of alcoholic pseudo-paresis have been referred to on page 36. In its quieter periods it of course resembles the state under discussion. The chief points of importance in the diagnosis, viz. the physical signs, are detailed on page 37. The distinctions between chronic hallucinatory delusions and G.P.I. are given on p. 73.

2. The distinctions between senile exaltation with excitement and G.P.I. have been indicated on page 47 and hold good for the same conditions without excitement.

3. Dementia paranoides with grandiose delusions may superficially resemble this phase of general paralysis. The latter is distinguished by the presence of :—Euphoria,

true expansive delusions, divertibility in mood and conduct, defects of memory, and physical signs : and by the absence of katatonia, the speech abnormalities of dementia præcox, motiveless conduct and chronic hallucinations of hearing, especially pseudo-hallucinations (*vide* Glossary).

(B) DELUSIONS DEPENDENT UPON AN UNPLEASANT CŒNESTHESIS

I. Hypochondriacal and Persecutory Forms

These varieties merge by imperceptible gradations into the depressed phase of general paralysis (*vide* p. 56) and in fact only differ from the latter in the absence or insignificance of that mood.

The delusional state may be of a hypochondriacal nature only (*e. g.*, head made of glass, bowels turned into worms), or include ideas of persecution—changeable and exaggerated. The delusions not infrequently show an admixture with ideas of grandeur, and the presence of a passing euphoria (*e. g.*, that the bowels are obstructed by diamonds or bank-notes).

Intellectual and volitional impairment together with relative emotional indifference (in view of the nature of delusions), and absence of proper emotional reaction as noted under the last syndrome are also present.

The delusional content may be of similar type to that of persecutory hypochondria, dementia paranoides, or melancholia.

Differential Diagnosis

1. From Persecutory Hypochondria :—

Present in G.P.I. :

Intellectual impairment, *e. g.*, defective perception, association and memory ; divertibility in mood

and conduct; indications of euphoria breaking through a mood of relative indifference to the unpleasant delusions.

Absent in G.P.I.:

Persistent prominent hallucinations, excitability, moods of considerable intensity with proper emotional reaction and in proportion to the nature of the delusion; conduct in accordance with the same; remissions as noted under persecutory hypochondria.

2. When katatonia and auditory hallucinations, or pseudo-hallucinations are not at once prominent in dementia paranoides, the distinction of late developing types from general paralysis is not always easy. Impairment of acuity of perception and of memory, especially for times and dates, divertibility of mood and conduct, and inability to do simple calculations point to G.P.I.

Mannerisms, purposeless acts, and the speech abnormalities, *e. g.*, neologisms, verbigeration, meaningless phrases, point to dementia præcox. Physical signs of G.P. are of course conclusive evidence.

II. Paranoidal Delusions in General Paralysis

The syndrome considered here is uncommon, and possibly its symptomatology is in part based upon a paranoiacal temperament in the patient, *i. e.*, the occurrence of the disease general paralysis in an individual already constitutionally abnormal.

It occurs in the early stages of G.P.I. and resembles an incompletely evolved case of querulent paranoia.

The delusions of persecution are possible and attributed to living persons, *e. g.*, a conspiracy organized by some individual whom the patient dislikes "to get him out of the way," etc.

The delusions are logical, and the conduct in accordance

with them. They show some systematization, a fitting in of some past or current unpleasant incidents with the scheme of present imaginary persecution. There are no appreciable demential symptoms ; volition and emotional reaction are normal. The demeanour is dignified and manifests the increased self-esteem of the paranoiac.

These patients resent their admission to the asylum in a perfectly normal manner. Prior to this, they have not infrequently retaliated upon their imaginary persecutors. Physical signs of G.P.I. are usually absent or very indefinite.

Now there are three points to which the attention of the observer should be directed in order to clear up the

Diagnosis

1. An exaggerated statement expressing a degree or kind of emotion or attitude of mind that is not in accordance with the patient's conduct, emotional state, or former character, should raise a very strong suspicion of G.P.I.

2. The possibility of—

(*a*) Discovering any doubt or uncertainty in the patient's mind concerning his delusions.

(*b*) Persuading him to disbelieve any part of them.

In paranoia neither feat is possible.

3. The fact that the conduct of paranoiacs does not bring them into conflict with their environment, and hence into asylums, until the systematization of their delusions is complete up to the present. In other words a paranoiac does not advertise, nor act anti-socially upon his erroneous judgments until they are logically co-ordinated into a delusionary whole.

The resemblance of these paranoidal syndromes in G.P.I. to the more systematised varieties of alcoholic

paranoia (*vide* p. 74) is marked. In most cases the correct diagnosis can only be reached by observing the following points :—

(*a*) The presence or absence of definite alcoholic deterioration, mental and moral (not always easy to distinguish from paralytic impairment) (*vide* Dementia, p. 112).

(*b*) The presence or absence of a latent euphoria.

(*c*) Careful note of the physical signs (*vide* p. 99).

Then, of course, these paranoidal paralytics may also be alcoholics. In which case the main point is to decide upon the presence or absence of G.P.I.

The history when available is a valuable aid to a correct diagnosis. The anti-social conduct of paranoiacs and alcoholics comes as no surprise to their acquaintances, because these two types have been gradually evolving and degenerating respectively, to the level indicated by the present anti-social acts which have brought them into conflict with their environment and hence under observation. Their causative change of character has been a matter of years. The delusions of the paranoidal paralytic are a comparatively sudden development and indicate a relatively abrupt change in personality, which could only be the result of recently acquired disease.

9. PARANOIDAL AMENTIA

This syndrome is a mild variety of amentia, in which the clouding of consciousness is slight and delusions are prominent.

Symptoms

1. Delusions of almost any content, often vague, confused, and contradictory, but implicitly believed in. The faith in the delusions can however often be transitorily shaken by suggestive conversation.

2. A changeable but sincere and fervent mood, manifesting great intensity of feeling, in accordance with the delusions. Commonly apprehension, with ideas of persecution, is present.

3. Conduct appropriate to the delusions.

4. Mental confusion, but no inaccessibility or imperception.

5. Hallucinations.

6. Cachexia.

Differential Diagnosis

1. From Dementia Paranoides :—

The following features of the amential syndrome are the basis of the distinction :—

i. The sincerity and depth of the emotional disturbances.

ii. Mental confusion (*i. e.*, concerning *external* events etc.).

iii. Conduct in accordance with the erroneous ideas.

iv. Cachexia, and short duration of the attack.

v. Absence of katatonia, catalepsy, motiveless conduct, etc.

2. From Paranoia :—

The distinguishing symptoms from paranoia are :—

i. Acute onset, and short duration.

ii. Great emotional disturbance.

iii. Confusion, and sometimes disorientation.

iv. Cachexia.

v. Hallucinations (cf. p. 62).

.vi Absence of logical connexion between the delusions, and of their gradual development upon a basis of preconception.

3. Persecutory hypochondria is excluded by the presence in the amential syndrome of violent emotional

conditions, confusion, cachexia, short duration, more continual hallucinations, absence of fixity in type of delusions.

Persecutory hypochondria, however, occasionally begins with an episode of acute confusion. These cases like all other mixed insanities are difficult to diagnose. The confusion is marked by an absence of rapid changes in mood, and indeed, the general emotional condition is much less intense than in true amentia agitata.

The patient talks incoherently, plays upon words but does not display disintegration of words, or meaningless speech. Again, he is more accessible than is the case in true amentia.

The distinction of these confusional states in persecutory hypochondria from paranoidal amentia are based upon the depth of the confusion together with the relatively apathetic mood, in the former.

4. From Delusional States in G.P.I. :—

The chief points in the diagnosis are :—The shallow emotions or apathy of G.P.I. and the physical signs. The confusion, hallucinations, and the absence of general mnemonic and intellectual impairment, in amentia.

5. Alcoholic "mania" is distinguished by a semi-humorous mood, uncertainty of the delusionary ideas, divertibility in mood and thought, physical signs of alcoholism, the prominence and persistence of hallucinations of hearing.

10. THE POLYNEURITIC PSYCHOSIS (Korsakoff's Syndrome)

This condition is an attenuated variety of intoxication, *i. e.*, confusional insanity, due in the vast majority of cases to chronic alcoholism. Other toxins, however,

productive as a rule of diverse forms of confusion, may occasionally produce Korsakoff's syndrome. This latter, when fully established, differs from the other forms of confusional insanity in the insignificance of the clouding of consciousness, in the presence of peripheral neuritis, as well as in the following features :—

1. The presence of prominent but shifting and changeable delusions in reference to the past, resulting from the characteristic pseudo-reminiscence. These patients relate long histories, more or less confused, of imaginary past incidents. Amnesia for recent events is marked.
2. Slight clouding of consciousness with only occasional disorientation.
3. Moderately good passive attention.
4. Accessibility, suggestibility, and divertibility, except that the patient cannot be persuaded of the inaccuracy of his delusions.
5. Absence of continuous hallucinations, except in the initial stage, which may be ushered in by delirium tremens or some other acute alcoholic or amential syndrome.

Prognosis

Cases of a year's duration may recover. As a rule a longer duration means permanent insanity ending in dementia.

Differential Diagnosis

The characteristic combination of features in this malady, viz.—polyneuritis, gross falsification of memory, and confusion are as a rule distinctive. Nevertheless, other chronic alcoholic syndromes may show some of the cardinal symptoms of this affection. This has been noted under chronic hallucinatory delusions in reference to pseudo-reminiscence. Indeed, all the alcoholic syn-

dromes merge into each other, and occur mixed, almost as frequently as they do separately. (Incidentally, the same statement holds good concerning the relationship between all the epileptic syndromes, the paralytic, confusional, and the dementia præcox psychoses, etc., as noted under their respective headings.)

CHAPTER IV

STATES OF STUPOR

The term stupor may be used in a wide sense to include those syndromes of mental disorder in which the predominant signs are varying degrees of immobility and mutism. When absolute, the different varieties are almost impossible to diagnose, nor are they always easy when the stupor is less marked.

1. CIRCULAR STUPOR

This condition is a phase of manic-depressive insanity, allied to melancholia, in which the impediment of will is sufficient to produce stupor. It is termed circular owing to its recurrent character, but the subsequent attacks may take the form of other manifestations of the manic-depressive diathesis, viz.—mania, melancholia, or mixtures of the two, which may also have preceded the stupor.

Symptoms

1. Immobility, at most occasional slow movements.
2. Mutism, though often a whispered reply may be obtained upon earnest persuasion. These result from impediment of volition.
3. Genuine depression with sad appearance.
4. Usually, delusions of melancholic character.
5. Collectedness with good perception, comprehension, orientation, and memory.

Prognosis and Treatment

These are along the same lines as for melancholia, and need little special comment. The patient should be kept in bed. Special attention should be paid to the skin of the back, etc. He should be fed by tube if necessary, at least three times a day. It is important to remember that these stuporose patients often suffer from insomnia, just as much as melancholics. They need as much feeding up and as many aperients; they are also benefited by massage. They are suicidal in many cases, as the stupor is developing or passing off.

2. KATATONIC STUPOR

Katatonic stupor is a well-marked phase of dementia præcox, and, indeed, evinces all the typical features of that malady, perhaps more fully than any other manifestation. It is a volitionally active stupor, the result of a perverted but powerful action of the will, without motive or psychical representation.

Symptoms

1. Immobility.
2. Mutacismus (forced dumbness).
3. Emotional vacuity.
4. Other katatonic or cataleptic features (*vide* Glossary).
5. Good comprehension, perception, orientation and memory.
6. Transitory attacks of other phases, *i. e.*, excitement or depression.

Prognosis

Temporary recovery sometimes occurs, to be followed later by relapse into the same or some other variety of

the disease. More commonly, the stupor merges directly into one of the latter, and the malady progresses without intermission. The temporary recoveries may persist for years, but usually they are not complete, a degree of stolidity, and seclusiveness remaining. Some cases amongst those that are recorded as recoveries are examples of amentia with katatonic signs (*see* p. 183).

Treatment

There is no special treatment indicated. Tube feeding may be needed for a while, and the patient should be kept in bed during the acute stage. One should be prepared for sudden purposeless violence, destructiveness or suicide. These cases are often wet and dirty in habits and so require a good deal of attention.

Differential Diagnosis

The distinctions from circular stupor are the presence of katatonic or cataleptic signs, *e. g.*, negativism, stereotypy (*vide* Glossary), transitory excitement or exaltation, if they occur ; and the absence of genuine unhappiness and impediment of will.

Cases of katatonic stupor often strike absurd or unnatural attitudes. Not uncommonly the dementia præcox smile may at times be seen—a smile that is causeless, vacant and silly or sly. This smile at once excludes a diagnosis of circular stupor. The dumbness in the latter is seldom absolute. It is due to an impediment of will which the patient vainly tries to overcome ; the effort can be observed, and moreover, is commonly successful to the extent of a much delayed whispered response to a question. The katatonic patient will not speak. He does not know why, but he is fixed and immovable in his determination. Exactly the same state

of affairs appertains in the realm of ordinary action. Katatonic cases will not do what they are asked; bad cases of circular stupor fail to do so because they cannot. Actual negativism is almost always present in katatonic stupor, never in the circular variety, although a certain amount of resistiveness, arising from apprehension, may be manifest (*vide* Melancholia, p. 50).

3. AMENTIA ATTONITA

This affection is a variety of acute confusional insanity. It is a passive stupor due to a high degree of clouding of consciousness. The patient does not act or speak, because he has no clear ideas to produce motives.

Symptoms

1. Acute onset.
2. Cachexia.
3. Immobility and mutism, more or less absolute.
4. Semi-consciousness, inaccessibility, imperception, disorientation.
5. Temporary lucid intervals, in which is manifest amnesia for events during the illness.
6. Apparent emotional indifference.

Prognosis and Treatment

In all essentials the prognosis and treatment are identical with those of amentia agitata.

Differential Diagnosis

1. From Circular Stupor:—

The presence of clouding of consciousness, imperception, cachexia, disorientation, and the absence of depression,

ideation, and memory—in amentia, are the main diagnostic features.

As noted above the stupor in amentia is due to an absence of mental pictures of internal or external origin, necessary to produce motives for volition. Circular stupor is due to an impediment of will, which the patient's promptings to action cannot overcome.

2. From Katatonic Stupor :—

The distinctions are obvious. In simple amentia, there is the semi-consciousness, imperception, etc., and no katatonia ; in katatonic stupor, katatonia or catalepsy together with clearness about surroundings. (But *see* p. 182.)

4. SIMPLE STUPOR IN DEMENTIA PRÆCOX

This is a variety of stupor without katatonia or catalepsy, but manifesting rapid changes of feeling, and as a rule, hallucinations and delusions.

From amentia, it is distinguished by the absence of clouding of consciousness, amnesia, imperception, disorientation and inaccessibility, cachexia, and lucid intervals.

The diagnosis from circular stupor is based upon the presence in dementia præcox of hallucinations, and the absence of persistent and genuine misery.

The basic apathy of dementia præcox is manifest in this simple stuporose condition. The patients frequently express apprehension and more or less gross delusions, *e. g.*, that their eyes are about to be gouged out, but they show very little distress.

There is one symptom that I have observed in these patients, which I believe is not found in any other variety of stupor. That is a subjective state of " puzzling." With complete clearness about the *status quo* and the surround-

ings, the patient is confused about himself, about his feelings and the ideas that come into his head. He has at first some recognition that he is ill, yet he cannot understand his thoughts, delusions, or hallucinations, which to him are an incomprehensible set of realities, nevertheless in the early stages he can be made to understand temporarily to some extent that they are due to the illness.

This condition is manifest in a peculiar puzzled stare, in the indefinite and halting fashion in which he expresses himself, in the aimless way in which he wanders or stands about, and by some patients, it is expressed in words.

These cases often initiate hebephrenia, that variety of dementia præcox in which katatonia is inconspicuous throughout and in which emotional disturbances are much in evidence. In the writer's opinion this self-puzzled state occurs at the genesis of all forms of dementia præcox and is, moreover, peculiar to that malady. As the disease progresses, it is gradually lost. Early cases manifesting it can by careful therapeutic conversation, suitable environment and treatment, be retarded in their progress.

5. EPILEPTIC STUPOR

Stupor in epileptics is an "equivalent," and is associated with fits or other equivalents, *e. g.*, excitement or depression.

Symptoms

1. Sudden temporary stupor, accompanied by more or less immobility and mutism.
2. Considerable clouding of consciousness and inaccessibility.
3. Short interludes of delirium with motor excitement.
4. Slow, clumsy intellectual and bodily action, and also speech when present.

Prognosis

As epileptic delirium.

Treatment

No special treatment is indicated. An aperient should be given, and as a precaution it is advisable in most cases to keep the patient in bed in a single room. When very "lost," he may stumble about and hurt himself; when delirious he may attack others.

As it will be inferred, these cases are simply stuporose varieties of epileptic delirium, bearing a similar relation to that condition as amentia attonita does to amentia agitata. And they should be treated as such.

Differential Diagnosis

Of the preceding varieties of stupor described, amentia attonita is the only one showing any real resemblance to epileptic stupor. Consciousness is to a great extent unaffected in the others.

The points to bear in mind in the distinction from amentia, are the sudden onset without cachexia, the short duration, and the appearance of phases of motor excitement. Even apart from the latter, the epileptic practically always shows some signs of both intellectual and emotional activity, which is of characteristic oppressed clumsy retarded type, whereas the ament is apparently devoid of all thought and emotion. One may perhaps compare the epileptic stuporose patient to a motor car which in spite of petrol will only produce spasmodic jerks and grunts, because its carburetter is sooted, in contrast to the ament who may be likened to a car in which the petrol is turned off.

6. STUPOR IN GENERAL PARALYSIS

Stupor is usually a transient phase in G.P.I. characterized by varying degrees of immobility and mutism and by the presence of other signs of the disease, *e. g.*, occasional expansive delusions, or ideas of an unpleasant nature marked by a latent euphoria, mnemonic defects, and other symptoms of intellectual impairment; and, physical signs. If the stupor always took this form, the diagnosis would be simple, but unfortunately such is not the case. Prolonged attacks of stuporose confusion occasionally occur which present no inconsiderable resemblance to amentia attonita.

All varieties of stupor in G.P.I. manifest some degree of clouding of consciousness, and for that reason may be regarded as stuporose and mild forms of paralytic delirium.

Prognosis

The majority of attacks only last a few days or a week or so, some however may persist for four months or longer. These prolonged types show remissions, increasing in length as the stupor begins to pass off, and are sometimes followed by a period of approximate normality, not uncommonly terminated by an attack of megalomania. So complete does the temporary recovery appear when the stupor has cleared up, that in some cases one momentarily doubts the diagnosis, especially when the physical signs clear up too—an occasional coincidence.

Treatment

As a rule these patients do not refuse food, although spoon feeding may be necessary occasionally. All cases

should be kept in bed, and the bowels and bladder carefully attended to. Retention of urine is sometimes present, but far more commonly incontinence of both urine and fæces.

The skin toilette must be scrupulously carried out (*vide* p. 27).

Differential Diagnosis

1. From Circular Stupor :—

The main points to be noted are the presence of the paralytic symptoms and signs noted above, and the absence of deep unhappiness and impediment of will. Some degree of confusion or imperception is present in the paralytic condition and, not uncommonly, disorientation.

2. From Katatonic Stupor the distinctions are usually obvious.

3. From Amentia Attonita :—

As noted above some of the stuporose paralytics bear a close resemblance to stuporose aments. They lie in bed motionless and apparently mindless, they do not speak or appear to understand what is said to them. They are to some extent cachetic, and when nearing the end of the attack, remissions appear, in which they are lucid, but evince amnesia for the illness.

Remissions in physical signs, perhaps already indefinite, render the diagnosis more difficult. Remissions in physical signs in G.P.I. are not confined to the stuporose types of the disease, by the way, but are exceedingly common in all varieties. That is to say, pupillary changes, patellar reflexes, tongue signs, and tremors, bladder and rectal indications, all vary from normal to abnormal from time to time.

To clear up the diagnosis attention should be paid to the following points :—

The presence of unequal, rigid or Argyll-Robertson pupils, even if transitory, means G.P.I.

The Remissions.—In paralytics the remissions are often incomplete, that is to say, they take the form of diminution of the stupor to the extent that the patient will reply to questions, but after a pause and in a word or two. And these partial remissions are the observer's opportunity to examine the patient's intellectual, volitional, and emotional signs and reactions. Complete lack of autocriticism, the presence of apathy, or signs of latent euphoria, indicate G.P.I. The lucid intervals in amentia attonita are much more complete, much shorter, and more frequent and they do not exhibit the above mentioned signs. A Wassermann test of the cerebro-spinal fluid should always be done in doubtful cases.

From Epileptic Stupor :—

The transitory mild attacks of stupor in G.P.I. are easily distinguished from epileptic stupor. The epileptic is much more stupefied and inaccessible ; in his less clouded phases he manifests the slow stumbling mentation of his class instead of paralytic divertibility, futility, euphoria, etc. The prolonged varieties of paralytic stupor of amential type can be distinguished from epilepsy upon similar lines to those suggested for the distinction of amentia from epilepsy (p. 92).

7. " MANIACAL STUPOR "

This condition is not very common. It is regarded by some, notably Kræpelin, as a form of maniacal depressive insanity which exhibits a mixed clinical picture composed of the symptoms of mania and melancholia at the same time. It is said to replace mania or melancholia occa-

sionally in a series of manic-depressive attacks. Be this as it may, there is no doubt that in its symptomatology it also bears some resemblance to an amential condition. There is neither the exuberance of mania nor the misery of melancholia. It should also be borne in mind that recurrence in more or less isolated attacks is not by any means confined to the manic-depressive psychoses.

Symptoms

1. Short periods of more or less immobility broken by restless disconnected action, tricks, and silly, but not motiveless, conduct.

2. Mutism, but for occasional unintelligible muttering and irrelevant or stupid remarks. Some cases are noisy, garrulous, and maniacal at times.

3. A moderate degree of imperception, with inability to combine percepts, confusion and disorientation; but good comprehension of simple conversation. Illusions of identity are common. The patient is easily accessible, but entirely misunderstands his surroundings and his relationship to them.

4. A variable, rapidly changing mood, manifesting a prevailing tone of sly cheerful facetiousness. Transitory apprehension, anger and superficial misery occur.

5. Divertibility, so far as the confusion permits.

6. Hallucinations are rare and when present probably indicative of exhaustion.

Prognosis

Recovery, sometimes after a year's duration, is the rule.

Treatment

The treatment should be on general lines. Nothing special is indicated.

Differential Diagnosis

Circular stupor is excluded by the absence of genuine persistent depression of spirits and mental pain; katatonic stupor by the absence of katatonia; amentia attonita by the presence of ideation, motor symptoms and emotional states, and by the absence of inaccessibility.

Simple stupor in dementia præcox approaches somewhat nearer to the clinical picture of "maniacal stupor." The main distinctions are the presence in the latter of confusion concerning external impressions, and of disorientation, divertibility, and sincere, if changeable, states of emotion; and the absence of motiveless acts (which are not infrequently to be observed in the hebephrenic) and the self-puzzled state already noticed.

The distinctions from epileptic stupor are too apparent to call for comment.

Maniacal stupor is distinguished from paralytic stupor or confusion, by the presence of more active mentation, livelier attention, interest, and emotional states, as well as by the absence of paralytic delusions and physical signs. The marked prolonged types of stupor in paralytics are not in the least like "maniacal stupor."

CHAPTER V

STATES OF MENTAL ENFEEBLEMENT

Mental enfeeblement is a feature of a large number of mental disorders, and is present to some extent in many of those already described. In some of these it is only of academic interest to distinguish the varieties of impairment, but in others its special features are of diagnostic importance. Then there are cases in which weak-mindedness may constitute almost the entire course, *e. g.*, imbecility and some gross cerebral lesions.

1. DEMENTIA PARALYTICA

Progressive deterioration from the onset, mental and physical, is characteristic of G.P.I. The dissolution of mental functions is in inverse order to their acquisition. In some varieties of the disease dementia is the most conspicuous mental feature throughout; probably this is the commonest type. The final state in all cases that weather the dangerous crises, is a condition of bedridden marasmus with almost complete abolition of mentation, only a few of the lower instincts such as those of eating and defence persisting.

Symptoms

The following are the chief symptoms of a moderate degree of paralytic dementia :—

1. Amnesia, chiefly for time and dates, often accom-

panied by inability to do simple calculations formerly accomplished with ease.

2. Absence of autocriticism.

3. Impaired passive attention and slow perception :— Imperception in later stages or confusional episodes.

4. Poverty of ideas (except in megalomania) and slow ideation. Loss of the power of forming concepts or combining percepts, so that only an imperfect idea of the general situation is present, and not uncommonly, disorientation.

5. A mood of apathy and lack of natural interest in the immediate surroundings. The emotional reaction to stimuli may be practically absent, or may manifest a childish superficial exaggeration.

6. Feeble volition, with divertibility in mood and conduct to a greater extent than in any other form of dementia.

7. Good, if slow, comprehension of conversation.

8. Some indications of euphoria, and perhaps persistence of some characteristic delusion or of other phases of the malady such as those already described.

9. Irrational conduct.

10. Alterations in the individual character.

11. Physical signs of G.P.I., *e. g.* Fine tremors of *lips*, *tongue* and *hands*, and sometimes of lower limbs, *trombone movements of tongue* on protrusion, *slurred speech with syllable stumbling* ; *pupillary changes, i. e., rigidity, Argyll-Robertson, myosis, or inequality* ; *amimia of lower facial area, increased knee-jerks with floppy return,* or their absence ; *Rhomberg's sign* ; unsteady spastic or tabetic gait ; *bladder* or rectal insufficiency ; dysphagia ; optic atrophy ; paresis of groups of muscles, *epileptiform fits,* etc.

Any or all of these may be present, the more common and those of most diagnostic significance are printed in

italics. It is important to remember that most of these physical signs are subject to remission.

Differential Diagnosis

The diagnosis from other forms of mental dissolution will be discussed later. It is perhaps as well here to suggest distinctive points between early G.P.I. and the ever increasingly common neurosis, neurasthenia.[1]

The budding paralytic is preoccupied and rather depressed; the quality of his work deteriorates; his power of application weakens; he is soon fatigued, and he grows moody and forgetful; he may also have hypochondriacal notions.

All these symptoms occur in neurasthenia. The following are some of the points of distinction :—

In neurasthenia these shortcomings meet with exaggerated notice and anxiety on the part of their subjects. If the paralytic observes them at all, he is not in the least put out thereby; and if they are pointed out to him, he passes them off with an excuse. In a word, the paralytic's autocriticism is defective. His depression is not in part due to self-observation, but to cœnæsthetic disorder.

The neurasthenic's passive attention and observation are morbidly acute; the paralytic's blunted, his perception slow. Hypochondriacal ideas in neurasthenia are productive of considerable dejection or agitation; in G.P.I. only very shallow emotion appears to be felt, and the ideas may manifest hintings of a coming euphoria or a grossness entirely at variance with the fancies of

[1] The term Neurasthenia is used throughout this work, unless otherwise stated, to include the true neurasthenic asthenia as well as the anxiety neurosis. In the vast majority of cases they do not occur as separate entities.

the neurosis. Indications of moral degradation and change of character at once exclude neurasthenia.

Sudden conspicuous transitory amnesia indicates G.P.I. or some psychosis. Some early paralytics, however, especially those belonging to the educated classes, even when euphoric, appear to suffer from transitory periods of clear insight. The condition in which they are, though even then not fully understood, fills them with a transitory blind horror and despair. These temporary returns of the power of autocriticism account for the suicides amongst early G.P.'s.

2. DEMENTIA PRÆCOX

Several phases of this disease have already been considered, and incidentally the features of the mental impairment mentioned.

Here the latter will be briefly grouped together. The reader is recommended to refer back to page 64 for quotations of the essential underlying signs of the malady. The final stage is the automatic dement of asylums—stereotyped, silent or talking unintelligible rubbish, self-neglectful, motiveless, without ideas, and almost without instincts, except that for food; and yet not disorientated, not affected in comprehension of conversation, nor amnesic.

Symptoms

1. Complete apathy, with loss of emotional reaction, interest and motives for action.
2. Poverty of ideas.
3. Greatly impaired judgment, instanced by ridiculous transitory or more or less fixed delusions, which are completely barren of results.

4. Often, persisting hallucinations or pseudo-hallucinations.

5. Motiveless conduct.

6. Remnants of earlier phases, *e. g.*, periodical attacks of motor excitement.

7. Some katatonic symptoms.

8. Unimpaired comprehension and knowledge of time and place, good perception and memory, so far as the complete indifference to surroundings permits.

Prognosis and Incidence

The type of adolescent most liable to develop dementia præcox is the reserved, seclusive, and self-contained; and when the psychosis develops in such individuals the outlook is hopeless. Initial acute manifestations occurring in persons of normal temperament are said to result in complete recovery, but many of the cases of this variety described, are obviously amential attacks with katatonic symptoms, or other psychoses. It is probable that normally vivacious, communicative and gregarious persons are immune from the disease.

Differential Diagnosis

The distinctions from dementia paralytica are too apparent to call for enumeration.

3. SENILE DEMENTIA

The majority of old people manifest some degree of mental impairment, but true senile dementia does not by any means invariably supervene. It is probable that its incidence implies some inherent or acquired defect in the cerebral mechanism. Senile dementia is regarded

as in part due to primary degenerative cortical changes (abiotrophy) in part due to secondary effects of cerebral arterio-sclerosis (arteriopathy).

As previously noted, these changes are associated with attacks of excitement, depression, etc., as well as productive of dementia.

Symptoms

1. Amnesia, chiefly loss of power to retain recent impressions.
2. Impaired power of attention.
3. Volitional feebleness and divertibility.
4. Emotional instability, usually with excessive reaction. The prevailing tone may be apathy, suspicion, resentment, depression, or exaltation.
5. Circumscribed egocentric childish ideation, with puerile interests and amusements. Sometimes a tendency to ideational inertia (*vide* Glossary).
6. Relatively active mentation within its horizon and when stimulated by external agents, with good comprehension of simple conversation.
7. Impaired perception; inability to associate percepts; and disorientation.
8. Physical signs of senility.
9. Sometimes focal symptoms, *e. g.* transitory aphasias, paraphasias, fits, thromboses, etc.

Prognosis

This is of course hopeless. The termination is a bedridden dement, helpless, and almost mindless. These cases live almost indefinitely in asylums, which, incidentally, are most unsuitable places for them.

Treatment

Nocturnal restlessness is the rule in these cases, and is best combated by purgation, chloralamide grains 15 to 20, or by paraldehyde in doses of 1 or 2 drachms at night. The patients are apt to wander about, so care should be taken that they do not fall down, fall into a fire, or interfere with others, and consequently be pushed over. Not a few fractures of the femur have resulted from this in asylums. They should sleep on low bedsteads.

Differential Diagnosis

Senile dementia cannot be mistaken for either of the preceding forms of dementia. Distinctions from subsequent varieties will be mentioned under their respective headings.

4. ARTERIO-SCLEROTIC DEMENTIA

This form of enfeeblement as the name implies is due to cerebral arterio-sclerosis. For the causes of the latter the reader is referred to other works. The clinical picture resembles in a general way that of senile dementia, which indeed is in part due to the same cause.

The main points of distinction are as follows :—

In Arterio-Sclerotic Dementia :—

1. The amnesia is general, and not particularly for recent events.

2. A more vacant mood is present, without undue emotional reaction, or senile changes in character ,*e. g.*, suspicion, egotism, cruelty.

3. Intellectual activity is less, but also less circumscribed.

4. Delusions, marked emotional disturbances, and confusion, are absent.

5. The conduct is not childish and silly, but sensible and orderly, so far as the dementia permits.

6. As a rule the patient is not physically senile.

7. A sense of illness is sometimes present.

Arterio-sclerotic dementia bears some likeness to Dementia Paralytica. The similarity is increased by the incidence or history of focal signs, pareses, etc., and transitory unconsciousness.

The chief distinctions are as follows :—

In Arterio-Sclerotic Dementia :—

1. The amnesia is mainly for remote and general events, not for recent, nor particularly marked concerning times and dates.

2. Autocriticism is not abolished, a sense of illness frequently being present.

3. Delusions are absent.

4. The conduct is logical and orderly.

5. There is often a marked tendency to rapid mental fatigue, *e.g.*, in the course of conversation. Ideational inertia sometimes occurs.

6. The typical physical signs of G.P.I. are absent (*vide* p. 99).

5. SYPHILITIC DEMENTIA

Gross cerebral syphilis may produce clinical pictures resembling or identical with that described as arterio-sclerotic dementia, and doubtless arising from the same proximate cause. Cerebral gummata occasionally result in conditions analogous to those instanced on pages 42–45.

But the most frequent result of cerebral syphilis is a simple dementia with amnesia, intellectual and voli-

tional inertia, and slight emotional depression. Whatever the mental symptoms may be, physical signs of gross cerebral disease co-exist.

Some cases of diffuse gross syphilitic brain disease involving meninges, vessels, etc., in their clinical manifestations closely resemble G.P.I. The distinctions between the two conditions are given below. Not a few of these cases, however, are practically indistinguishable in life; the diagnosis is only cleared up on the post-mortem table. This is no matter for surprise, when one reflects that the cause of the two affections is the same; the ætiological difference being merely one of localization and relative coarseness of lesions.

When present the following distinctions from dementia paralytica incidentally indicate the type of Syphilitic Dementia in general:—

1. The onset is usually relatively sudden, within five years of infection.

2. The amnesia in view of the prominent physical signs is less marked.

3. Ideation and perception are more active in proportion to the physical signs.

4. Autocriticism is not destroyed—a definite sense of illness being present.

5. Orientation in time and space is not lost.

6. Euphoria and expansive delusions are not very common.

7. The conduct is not irrational, nor is there any marked change in character or personality.

8. Episodic excitement, confusion, etc., is sudden and pronounced.

9. Physical signs of coarse cerebral lesions are almost always present, and occasionally tertiary symptoms in other parts.

10. The remissions in mental symptoms and physical

signs which are sometimes seen in G.P.I. almost invariably occur in syphilitic dementia.

Prognosis

On the whole the outlook is unfavourable. The majority of cases appear to be unaffected by mercurials and iodides.

Treatment

Anti-syphilitic treatment should of course be tried, intra-muscular injections, inunctions, or intrathecal medications, as well as salvarsan.

6. EPILEPTIC FEEBLE-MINDEDNESS

Chronic epilepsy tends to dementia, although in some cases the enfeeblement is negligible. The more frequent the fits, the deeper the dementia ; the younger the patient at the onset of the fits the more rapid is the mental degeneration. Some cases reach a very high degree of enfeeblement in which almost all mentation is destroyed.

The type of dementia is set out in the following

Symptoms

1. Slow, clumsy thought, limited to the patient's immediate environment. Poverty in ideas.
2. Retardation in comprehension of simple remarks resulting in a slow reaction to questions in spite of excellent attention.
3. Amnesia, chiefly for remote events and general incidents.
4. Collectedness and clearness about surroundings and time.

5. Slow, childish, but formal and unnecessarily detailed speech exhibiting a very limited vocabulary.

6. A mood which is usually described as "wound up," *i. e.*, the patient is prone to emotional outbursts upon slight provocation.

7. Slow awkward movements.

8. Orderly and even fastidious conduct, apart from "equivalents."

9. Understanding of the illness from which the patient suffers, but a groundlessly optimistic view of it.

10. The occurrence of epileptic fits and "equivalents."

11. A serious character or temperament in which selfishness, excessive self-esteem, sensitiveness, obstinacy, perseverance and power of application, are mingled with an external piety and deep vindictiveness.

Epileptics are said sometimes to lack all altruism and to be viciously cruel, on the ground that they occasionally commit brutal crimes, etc.

This statement is hardly fair, the truth of the matter being that nine-tenths of the crimes so committed are the result of some form of pathological explosion.

Treatment

In dealing with epileptics in asylums, that is to say, with those whose conduct or dementia has brought them into conflict with their environment and hence caused them to be labelled in a separate class as insane epileptics, each case must be studied and considered on its own merits. The indiscriminate use of bromides is to be condemned. Cases too deeply demented ever to be fit for discharge are better without bromides altogether, occasional fits being preferable to continual wretchedness broken by episodes of violence and excitement.

Some cases do well on hyoscine hydrobromide by the mouth, some on chloral hydrate, the majority on nothing at all, except regularly administered aperients.

Limitation of diet in these cases merely produces resentment.

If an epileptic suffers from continual fits which tend to result in dangerous falls or to incapacitate him for occupation, he must have bromides, and perhaps the best combination is the triple salts with arsenic and nux vomica.

As mentioned before, tact, kindliness, unpatronizing sympathy and consideration, of course combined with firmness, are essential in managing insane epileptics, and for that matter, sane ones as well. Never treat an epileptic with condescension or nonchalance, but as an afflicted equal.

Make a friend of him, he will remain one to the end; and in many cases apart from his equivalents (and even to some extent in them) he will be as wax in your hands. Epileptics are excellent readers of character, so eschew all mere show of sympathy and kindness or you will be detected at once and distrusted.

Avoid even well-meant deception, or the patients' confidence may be forfeited for ever. In a word, the whole secret of managing epileptics, and indeed all comparatively lucid mental cases, is to feel as well as appear a brother to them. If a man cannot achieve this attitude he had better not take up the study and treatment of the insane.

Chloral hydrate grains 30, per rectum, is useful in recurring fits (*i. e.*, series). Actual status epilepticus, in which the patient has a series of fits without an interval of consciousness between, calls for chloroform inhalation in addition. All epileptic equivalents should be treated by aperients.

Differential Diagnosis

1. From Dementia Paralytica :—

Present in epilepsy—absent in G.P.I. :

(1) Limitation of ideas to the immediate environment, with

(2) Good attention and power of mental application within this circumscribed horizon.

(3) Clear understanding of the general situation.

(4) Autocriticism and a sense of illness.

(5) Amnesia for remote and general events.

(6) The epileptic temperament.

Present in G.P.I.—absent in epilepsy :

(1) Apathy, with or without a basic euphoria ; feeble emotional re-action.

(2) Impaired volition with childish divertibility.

(3) Irrational conduct, even apart from episodic disturbances.

(4) Relatively rapid comprehension and mentation generally.

(5) Amnesia mainly for times and dates.

(6) Physical signs.

The points of distinction suggested, are those between only a moderate degree of paralytic dementia and epileptic dementia. Advanced G.P.I. cannot be missed.

2. From Senile Dementia :—

The following points in senile dementia are the main diagnostic features :

The type of amnesia, the impaired attention, volitional feebleness, defective perception, disorientation, in conjunction with relatively rapid comprehension and mentation generally.

3. From Dementia Præcox :—

Present in epilepsy :

(1) Effective but slow mentation within a limited

horizon. This is productive of useful association of ideas and results in motives and subsequent action.

(2) "Wound up" mood.
(3) Logical conduct.
(4) Rational but childish speech, with limited vocabulary.
(5) Epileptic character.
(6) Amnesia.
(7) Sense of illness.
(8) "Equivalents" or periodical fits.

Present in dementia præcox:

(1) Quicker but perverted ineffective and valueless mentation of wider scope. This is sterile, resulting in nothing useful.
(2) Complete apathy.
(3) Motiveless conduct, with some katatonic signs.
(4) Pedantic absurd talk, full of long words, neologisms, and meaningless phrases.
(5) No character.
(6) Attacks of characteristic type, which have been outlined. Cases of dementia præcox not infrequently have one or two isolated fits in the course of the disease.

4. From Arterio-Sclerotic Dementia:—

The presence in epilepsy and the absence in arterial dementia of the following features, is important in the differentiation; sustained power of attention and intellectual application, the "wound up" mood, the epileptic character, clumsy retardation of thought, speech, and movements, periodicity in fits, and the occurrence of equivalents.

5. From Syphilitic Dementia:—

In syphilitic dementia there are remissions in the

dementia, and there are physical signs ; there is no retardation of mentation of epileptic type, no epileptic mood or character, and no periodicity in fits or episodic mental disturbances.

7. ALCOHOLIC DEMENTIA

All alcoholics do not become definitely weak-minded, any more than all old people dements. Probably some cerebral factor of inherent character is also necessary. Some of the features of alcoholic enfeeblement have already been referred to.

Symptoms

1. Semi-humorous, semi-irritable mood.

2. Amnesia, mainly for recent events. This may be of high degree so that the patient forgets what he has been told a few minutes previously.

3. Loss of higher moral control resulting in selfishness, lying and brutalization of conduct.

4. Impaired power of attention ; poverty of thought and interests and limitation of intellectual horizon.

5. Defective judgment, shown sometimes by ideas of persecution, grandeur, jealousy of conjugal fidelity, etc., all intrinsically possible however improbable.

6. Volitional feebleness and divertibility in conduct, except when the patient is under the influence of an immediate dose of alcohol and hence enraged or excited.

7. Physical signs of chronic alcoholism (*vide* pp. 34 and 37), including the alcoholic facies.

Differential Diagnosis

1. From Dementia Paralytica :—

Stress should be laid upon the following symptoms in G.P.I. :

Apathetic mood, amnesia mainly for time and dates,

inability to do simple calculations, absence of auto-criticism and of understanding of the general situation. Impaired perception, irrational conduct, and physical signs (*see* pp. 37 and 99).

2. From Senile Dementia :—

An old alcoholic will present mingled symptoms of the two conditions. A middle-aged alcoholic will be distinguished by his age. The main difference in the type of dementia can be seen from the detailed symptoms of the two conditions, but are of academic interest only.

3. From Arterial Dementia :—

The arterial dement suffers from general amnesia ; in character he is more or less negative, and in mood indifferent ; he is more passive and anergic, and may present ideational inertia and focal signs. The alcoholic's mnemonic impairment is mainly for recent events, his mood jocularly surly or irritable ; in character he is a feeble sort of blackguard ; and he manifests alcoholic physical signs and sometimes delusions and auditory hallucinations.

Naturally the two conditions may co-exist.

4. From Syphilitic Dementia :—

Syphilitic dementia is mainly distinguished from alcoholic by the presence of focal signs, by the remissions, the general amnesia, and the absence of the alcoholic mood and moral degeneration.

Moreover, the former class of patient has the indescribable appearance peculiar to gross cerebral disease—an appearance and demeanour that frequently enable one to say at once that some organic gross lesion is present long before any actual diagnosis is arrived at. There is a general and marked lack of alertness, an aspect of oppression and helplessness peculiar to these sufferers.

Dementia præcox and epileptic dementia cannot be mistaken for the alcoholic variety of enfeeblement, though, of course, the two latter may co-exist. When this is the case, the result may be one of the worst types of insane criminal.

The whole list of signs peculiar to epileptic dementia, given on page 107 except No. 4, are absent in pure alcoholic dementia ; and in epilepsy are absent the alcoholic semi-humorous mood, impaired attention, volitional weakness, and the physical signs.

8. APOPLECTIC DEMENTIA

There is no difficulty in the diagnosis of this condition. The usual features are : hemiplegia ; aphasias ; childish, extreme emotionalism ; persistence of former motor impulses ; without disorderly conduct, disorientation, or confusion about the general situation.

9. IMBECILITY

Imbecility as described here is regarded as the final expression of the " degeneration " of the stock. It is a spontaneous arrest of mental development due to inherent factors and is to be distinguished from congenital idiocy (due to fœtal or infantile cerebropathies) which is an acquired pathological condition. Cerebropathic idiots manifest some signs of past gross cerebral lesions, *e. g.*, paralysis or epilepsy, and their psychological characters are essentially negative.

Symptoms of Imbecility

1. Limited intelligence and circumscribed intellectual horizon ; absence of general knowledge, general ideas, concepts (*e. g.*, abstractions, such as, truth, evil), and of imagination.

2. Carelessness of the future, absence of plans or hopes.

3. Absence of critical faculty, resulting in misplaced excessive credulity and distrust.

4. Excellent passive attention and rapid perception, but feeble voluntary attention easily distracted by chance percepts.

5. Good memory for facts ; that is to say, simple things that happen to have made an impression.

6. Active emotional states, with great play of facial expression and excessive emotional reactions.

7. Impertinence and absence of modesty.

8. Limited vocabulary, and usually, defective articulation.

9. A childish character, in which vanity, fickleness, jealousy, cruelty, absence of altruism, pretence and mimicry, play important rôles ; together with inability to apply and a tendency to all forms of immorality.

Prognosis

Facts can be instilled into an imbecile, but he is incapable of applying them to his life. As Tanzi has it, imbeciles can be instructed but not educated.

The vast majority of imbeciles are at large. These anomalous persons are prone to acquire psychoses, just as are paranoiacs, and the disciples of the latter consist for the most part of the former.

Differential Diagnosis

It is only necessary to suggest distinctions between imbecility and the three following psychoses :

1. Diagnosis from Epileptic Dementia :—

In epilepsy, comprehension and mental action generally is retarded ; in imbecility, both are rapid. Memory

is often impaired in epilepsy, excellent in imbecility. In the former there is good power of voluntary attention and of application; in the latter the reverse is the case. Finally a sense of illness exists in epileptics, whereas the imbecile is wrapped up in a very perfect self-satisfaction.

2. Diagnosis from Dementia Præcox:—

In dementia præcox, general knowledge and ideas are present but useless; the vocabulary is anything but childishly limited; the mood is apathetic and the emotional reaction defective or nil.

Some imbeciles, however, develop dementia præcox at an early age, and in a year or so become extremely demented.

3. Diagnosis from Chronic Hypomania (*vide infra*):—

The subjects of constitutional excitement of slight degree conduct their lives very much after the fashion of high-grade imbeciles. They not infrequently squander money, disgrace their friends, come into conflict with the law, etc. But psychologically the two conditions are opposed. The hypomaniac is full of changing schemes and plans; he has quite fair general knowledge and power of conception and abstract thought, and a rather too vivid imagination. His disorder of conduct results from his exuberance triumphing over his better judgment and his critical faculties. The imbecile's life is due to the lack of these faculties and the absence of those powers, as well as his feeble sense of morality. Moreover, there are no defects in vocabulary or articulation in hypomaniacs.

PART II

ATYPICAL AND COMBINED PSYCHOSES

CHAPTER VI

BORDERLINE PSYCHOSES

1. HYPOMANIA AND THE MANIC-DEPRESSIVE DIATHESIS

A SMALL proportion of persons who pass muster among their fellows as "highly strung or excitable," are in reality the subjects of chronic hypomania or the manic-depressive diathesis—a temperament rendering them more liable to attacks of melancholia and mania, or mania alone, than ordinary persons, but shading off into the normal. The majority of them are also prone to minor attacks of depression (usually dubbed "blues" or "liver"), which are regarded as the counterpart of the depressed phase of manic-depressive insanity. In well-marked cases the constitutional excitement results in a life of prodigality, dissipation, ill-directed and spasmodic labour, without any perseverance or fixity of purpose. These persons are for ever planning, scheming and expending vast quantities of energy along continually changing channels.

As the result of any particular stress or of persistent opposition, they are very prone to develop definite attacks of manic-depressive insanity. It is not unlikely that such attacks, whatever their exciting cause, are the result of a process of auto-intoxication.

The general resemblance of their conduct to that of imbeciles has been noticed under the latter title.

All their symptoms are those of mania (or in their less frequent and conspicuous depressed phases, of melancholia) attenuated. In the first case for example—press of occupation, exuberance, defective power of sustained attention to one topic, rapid mental action, emotional instability, and general alertness, are exhibited. These cases are to be distinguished from the subjects of the hysterical temperament, because the latter are very much less likely to become insane as the result of some buffet of fortune.

Hysterics are also subject to periods of emotional and intellectual exaltation, but these are almost invariably the result of some external cause, however slight. They are lifted up to the skies by trifling pleasurable incidents and just as easily depressed by those of opposite nature. The hypomaniac in his usual condition is not easily subdued by any external agency. Until his depressed stage comes along, if he be subject to one, he is not sensitive, except in his pride, nor self-critical; he has none of the personal misgivings that are the daily lot of the hysterical person. After a bout of exaltation, in itself very short (in contradistinction to hypomaniacs' prolonged or permanent states), the hysteric practically always suffers a stage of this self-analytical depression as a reaction.

The periods or continual state of exaltation as well as occasional periods of depression in hypomaniacs are the result not of external but internal causes, and arise independently of circumstances, although naturally they may be modified thereby.

Chronic hypo-melancholics present a picture of attenuated melancholia. They seldom exhibit any exalted stage at all. Many of them worry about their physical health, which they hit upon as an explanation of their

depression ; and these cases are not easy to distinguish from constitutional neurasthenia. The importance of the distinction lies in the fact that neurasthenics under stress of circumstances as a rule merely tend to get an acute exacerbation, whereas hypo-melancholics tend to become melancholics ; a very great practical difference involving the question of the relative liability to suicide.

The diagnosis is mainly made from the presence of the physical symptoms of neurasthenia, and upon the fact that irrepressible ideas and other psychasthenic signs are much more common in the neurosis. In neurasthenia there is also more suggestibility and divertibility in mood than in the other condition. Neurasthenics moreover do not suffer from the continual depression of even mild melancholics, nor from impediment of will.

The points suggested above are the result of practical experience, but there is some reason for thinking that a certain ætiological relationship exists between the manic-depressive syndromes and neurasthenia, psychasthenia, the anxiety neurosis, and even amentia. This theory is supported by a certain family resemblance in symptoms, as well as by the view now commonly held that they are all due in part to some metabolic disorder resulting in auto-intoxication. Neurasthenics with psychasthenic symptoms suffer from irrepressible ideas, as well as unpleasant somatic sensations, indecision, and emotional depression ; melancholics, usually mild types, exhibit one or more unpleasant obsessive ideas which they cannot banish, painful somatic sensations with impediment of will and a much deeper emotional depression. In neurasthenia uncongenial occupation of the mind becomes a positive mental pain ; in melancholia all mental action is painful. Melancholics frequently manifest physical signs of neurasthenia, especially in the early stages. Hysteria is probably

closely related to psychasthenia and the anxiety neurosis psychologically (*see* pp. 128 and 135).

Of course, as noted above, there are well marked clinical distinctions between neurasthenia and melancholia which enable a diagnosis to be readily made in the case of ordinary severe melancholia; for example, apart from the depth and constancy of the depression, melancholics' ideas are frequently delusionary (which is never the case in neurasthenia), and therefore opposed in clinical character to the incoercible ideas of neurasthenics. Nevertheless obsessive ideas may develop through a phase of doubt into delusionary convictions, and some cases of melancholia exhibit all three phases. Self-depreciation is not nearly so common in neurasthenia nor so well marked when present, as in melancholia.

The exciting causes in acute cases of neurasthenia are just as likely to produce a picture of amentia.

Occasionally the latter is the culminating condition in severe cases of the former.

Exhaustion symptoms of amential nature are commonly seen in both mania and melancholia of acute type.

Again, mild amential delusional cases in which the erroneous ideas are rather felt as doubts bear no inconsiderable resemblances to anomalous psychasthenic patients.

The so-called maniacal stupor is believed by some alienists to be an amential syndrome, and not a manifestation of manic-depressive insanity at all.

Stoddart describes a condition "Anergic Stupor" as a variety of intermittent insanity, *i. e.*, manic-depressive insanity, distinct from melancholic (circular) stupor; and the symptoms he records are practically identical with those seen in what the present writer has called amentia attonita. This stupor is said to follow "melan-

cholic stupor or post-maniacal stupor" as a rule, but sometimes to occur primarily.

Now, as noted above, this type of case has been relegated to the amentia group, but it is probable, if it develops imperceptibly in sequence to melancholic or maniacal syndromes, that it must be a manic-depressive condition with exhaustion symptoms of so severe a type added, as to render it indistinguishable from primary acute amentia attonita.

The above notes are merely suggested as indications of some underlying related ætiological factor, and cast no doubt upon the clinical entity of the various syndromes concerned.

2. ECCENTRICS, CRANKS, MORBIDLY SUSPICIOUS PERSONS, CHRONIC PROPAGANDISTS OF IMPRACTICABLE SCHEMES, ETC.

These persons are for the most part cases of paranoia without delusions, possessors of the anomalous combination of a logical mind, an inflexible will, a passionate emotional temperament abnormally suppressed, and an inherent tendency to preconception. The features of paranoia have already been outlined, but the development of delusions is not necessary as an indication of the constitution or temperament. It has already been suggested that the basis of the temperament is due to perversion or disorder of instinct.

Examples are to be found among inveterate recluses (the potential victims of imaginary persecution), misers, diet cranks (such as vegetarians), originators of new religions, immoderate idealists, militant suffragette leaders, eternal litigators, monomaniacs (persons who subordinate the important things of existence to one fixed and immaterial view of life, or idea).

These persons, the subjects of an intense egotism, are always leaders of any paranoiacal movement which, incidentally, they pursue with indefatigable determination, active intelligence, and in a logical manner given the truth of the erroneous preconception at its base. Even when the utopian condition for which mattoids (the so-called altruistic paranoics) strive, is in fact altruistic, one never finds them doing obscure spade work.

In short, mattoids are hypocrites and self-deceivers, boasting an altruism which is merely a cloak for selfish love of power, display or homage.

Paranoiacal propagandists are not to be confused with hypomaniacs. These latter never devote their whole lives, indeed, very rarely more than a few months on end, to one scheme ; moreover, they exhibit the usual signs of attenuated mania, directly opposed to the inflexibility of the logical well considered and dignified conduct of the paranoiac.

Some eccentrics and recluses are persons subject to impulses of psychasthenic nature, or arrested precocious dements with some persisting katatonic tricks, which they wish to hide, or other more obvious lunatics. But they are easily distinguished from the paranoiac. For example, all militant suffragettes are not mattoids ; by far the majority are unstable women finding a vicarious outlet for an emotional suppression ; some are high grade imbeciles ; not a few hypomaniacs and hysterics.

3. PSYCHASTHENIA

Apart from depression, and cœnesthetic apprehension, and liability to " mental " fatigue, psychasthenia is par excellence the mental concomitant of neurasthenia. The two syndromes however occur separately. It is not proposed to discuss the various clinical states of neurosis

included under the heading of neurasthenia, they are described in textbooks of medicine. When the term is used alone in this book it means neurasthenia together with anxiety neurosis.

As Tanzi has it, psychasthenia (which he personally regards merely as a manifestation of neurasthenia) is the expression of a diathesis of psychical incoercibility. It includes three main features any of which may occur alone, or more commonly perhaps, one is prominent and the others rudimentary; but all three may be well marked in one case.

(*a*) Irrepressible Ideas.—These are ideas which continually recur to the patient's mind at intervals and quite irrelevantly to his current of thought.

He banishes them from consciousness after a struggle, but they merely represent themselves with added persistence and accompanied by a more unpleasant emotional tone for further argument and conflict, until in severe cases he becomes agitated and distressed almost beyond endurance. The irrepressible ideas sometimes take the form of

(*b*) Obsessions to Action.—They partake of the same character of incoercibility, produce the same conflict, and the same distress. They are of two main types, one in which the impulse is to some action that the patient regards as wicked, and hence which is never (or only under very exceptional circumstances) yielded to; and the other in which the obsession is apparently of indifferent nature to which the patient almost invariably yields after a struggle. If he decides to hold out against the obsession the result is mental torment until in the end he capitulates.

(*c*) Phobias.—These are specialized fears of specific things, *e. g.*, the fear of spaces, open or closed; of microbes, responsibility, blushing, etc.; there are about twenty of

these special phobias, all of which have received euphonious names.

The basis of all the psychasthenic symptoms is regarded as a more or less subconscious constitutional fearfulness (constituting a temperament which shades off into the normal)—a disturbance of the subconscious instinctive ego (*see* p. 128). Psychasthenics are perfectly lucid and sane, and moreover, enjoy a perfect autocriticism. Some unfortunate individuals are sufferers from this unpleasant syndrome throughout their lives, others only when in ill-health.

Those who yield to obsessions to action not infrequently come under the notice of the alienist ; and in the case of young people their apparently purposeless acts occasionally suggest dementia præcox. With care there is no reason why the two conditions should be confused : even the superficially similar conduct is essentially opposed. The psychasthenic acts after a miserable struggle to overcome the impulse ; the precocious dement acts with complete cynicism. It must not be forgotten, however, that the latter type of case not infrequently manifests neurasthenic and psychasthenic symptoms at the outset.

The following case is a common example exhibiting several features of interest.

The mother of a young man of 23 consulted the present writer about her son, because he was depressed and moody and suffering from irrepressible ideas. His conduct was also markedly disordered. He was with great difficulty persuaded to rise in the morning ; he took a couple of hours to bathe and dress, and at his worst times would lie in his bath for some hours, and even then only get out after his mother had washed him ! She would call him, and he would agree to rise ; then, after the lapse of half an hour or so, he would be found still in bed ; then fol-

lowed another promise to get up which would not be kept, until she remained with him and insisted upon his rising in her presence. The same performance occurred in his bath, culminating at times in the fashion recorded above.

On seeing the son, one noted that his health appeared good ; he manifested no signs of neurasthenia ; and his manner was quite normal.

A devout worshipper at the shrine of psycho-analysis would doubtless have proceeded at once to psycho-analyze, and after much soul-searching and reducing the patient to a state of nervous exhaustion, would have succeeded in unearthing some suppressed sexual conflict which lay almost on the surface of the soil, to be obtained for the asking.

The boy was quite frank, and a few moments of sympathetic conversation rendered the case quite clear. His irrepressible ideas did happen to be of sexual nature ; he had practised masturbation and felt very guilty therefrom. His conduct was the combined result of a subconscious sense of uncleanness and his struggles with his irrepressible ideas, which he had to banish repeatedly before and during the process of dressing, etc.

His mother was a neurotic widow ; his father a drunkard ; he himself a spoilt, carefully protected and mother-mollicoddled boy. He knew nothing of life, except art ; had no fixed occupation, and had never associated with other boys, although he had never been particularly delicate or subject to nervous affections. (In point of fact, he looked the picture of health, stout and rosy).

Common-sense conversation and advice effected considerable improvement, but both mother and son declined to adopt the alterations in the mode of the patient's life that were suggested, and so after a few weeks the case was lost sight of for some months. When seen again there were no complaints of his conduct nor did he

confess to any further attacks of irrepressible ideas or impulses.

The following theories concerning the neuroses are favoured by the present writer :—

The ordinary environmental conditions of life tend in certain individuals to produce undue reactions to fear. Expressions of this fear (involving the conscious admission of the conflict between environment and instinct), in such persons are suppressed into the subconscious, but when the suppression fails, perhaps as the result of worry or ill-health, and the failure is partial, the emotional tone of fear returns to consciousness disguised as an irrepressible idea, phobia, or obsession to action. Thus is psychasthenia produced. The constitutional fearfulness is the psychasthenic temperament, constituting a liability to such symptoms, but *shading off into the normal*. Complete failure of suppression and disguise, from worry, illness, etc., etc., resulting in conscious conflict, produces in such persons the anxiety neurosis (agitated neurasthenia). Auto-intoxication is associated with the anxiety neurosis (as well as with asthenic neurasthenia), and if very severe, may result in amentia. Persons without obviously psychasthenic temperaments may, of course, suffer from the anxiety neurosis and amentia, but the exciting conditions must be more severe in such cases. Pure asthenic neurasthenia is not associated with the psychasthenic temperament, but is due to an overdraft on the individual's capital of nervous energy. Constitutional types simply indicate that ordinary life constitutes this overdraft in their case.

4. "MASKED" EPILEPSY AND AUTOMATISM

The episodic attacks, permanent psychopathic states, and temperament of epileptics have already been noticed.

These were considered when associated with fits. Some persons however are met with who do not appear to suffer from fits (major or minor), or obvious psychoses, nor betray any signs of mental enfeeblement; but manifest certain slight anomalies of temperament and mental life which are usually attributed to larval epilepsy.

The most common of these manifestations is depression of spirits, periodical and causeless so far as external circumstances are concerned. Regularly once in every few weeks a feeling of gloom overtakes these patients; life seems dark and difficult and they become miserable and irritable, or bitter. They shun their acquaintances, to whom they are rude or churlish. Intimate knowledge of these persons sometimes enables one to demonstrate occasional nocturnal enuresis or tongue-biting, momentary attacks of giddiness or confusion, and always some indications of the epileptic temperament. They are sensitive, conscientious, painstaking, and of a serious turn of mind; but if offended, they are vindictive and manifest the obvious "wound-up" temper; they brood over imaginary "slights," and, more especially at the depressed period, are apt to imagine that they are insulted, and generally to misconstrue their friends' manners and remarks. Violent outbursts of rage without much provocation are common.

But these characteristics represent the full extent of their permanent psychopathic abnormality; actual and repeated fits appear to be essential in the production of any degree of intellectual enfeeblement.

The periodical attacks of depression culminate in some persons in an alcoholic debauch (an act entirely contrary to their usual tendencies), followed in a few cases by an attack of confusion or some other state of excitement. These are the so-called dipsomaniacs.

The periods of gloom are equivalents, and are therefore

frequent, causeless, short in duration (a few days), similar and periodical. These features distinguish them from other forms of depression. The temperament is regarded as a special variety of inherent instability, the possessor of which is particularly prone to develop epileptic episodes and fits. In not a few of the cases of this type, a history of fits, night-terrors, somnambulism, etc., in childhood, is forthcoming.

The importance of recognizing masked epilepsy lies in the fact that its subjects may at any time under stress of circumstances develop definite epileptic syndromes or fits.

Automatism (roughly to be described as apparently conscious action committed in a semi-conscious dream-like condition and subsequently forgotten) occurring in sane people, apart from hypnotism, is in the writer's opinion an expression of epilepsy or hysteria. Some patients while in this state appear to behave, to casual observers, as if nothing was amiss, showing that consciousness is not so much clouded as dissociated from that characterizing the ordinary life of the patient. In these types the sense of personal identity is not lost; the intellectual life is merely cut up into separate periods, the normal and the automatic, mutually forgotten in the other, and not infrequently remembered in the same; that is to say, similar representations may occur in each successive attack of automatism accompanied by recollection of the events of previous attacks which in the normal periods are completely irrecoverable; also much more rarely, temporary retrograde amnesia extending over previous normal periods (as well as automatic) may be present after an attack.

A soldier was admitted to my wards in a state of complete disorientation. He thought he had just come down the line to Fricourt and that the hospital was a

rest camp at that place. He was completely accessible, talked logically, and it was impossible to convince him by argument that his ideas were erroneous. He said however that he had dreamt that he had been invalided home. When taken outside the hospital and shown the sea, landscape, and passers-by, he "woke up" gradually, and immediately complained of pain in his head and became rather agitated and emotional. (*See* hysteria, p. 146, for psychology of cases of this sort.)

The automatism in these cases may persist for some weeks, and is to be regarded as hysterical. Other much more common varieties of automatism are shorter and obviously insane, *e.g.*, when blind, purposeless or criminal acts are committed. These for the most part occur in known epileptics or masked cases under the influence of alcohol.

One of the best marked attacks of automatism that the present writer has encountered was in a soldier of twenty-one years of age who was recently admitted to the observation wards of a military hospital.

On admission he was stuporose and mute; he obeyed simple commands, but appeared completely disorientated and vacant. Yet there was no individual imperception, nor active disorder of conduct. Physically, there was nothing worthy of note, but dilated pupils and an old bullet wound in his chest.

The following day he was completely collected and reasoned logically; by inquiry he had discovered his whereabouts, and in all save one particular was mentally normal, viz. he exhibited complete amnesia extending backwards for about three years from that day. For example, he found in his pocket a photograph of a woman and a baby. He showed this to me with the remark that the woman was the girl he was "keeping company with," but whose baby it was he had no idea. He

thought that the present year was 1912, and that he was in the Grenadier Guards, as in fact he had then been. He only discovered the loss of these three years from conversation with the other patients, from whom he also obtained the news that a war was in progress! On the next day he received a letter from the "girl he was keeping company with." She had been his wife for over two years, and the child in the photograph was his own.

During the succeeding week his memory gradually returned, much to his own satisfaction, until eventually he remembered everything, except some half-dozen short periods in his life, periods ranging from a few hours to some days, of which he was cognisant only from the accounts of his friends. These mnemonic scotomata proved upon inquiry to have been attacks of automatism. During each attack he had attempted suicide, twice by drowning, once by throwing himself on to a railway-line, once by shooting himself with his rifle (the result of which was the scar mentioned) and in other ways. On one or two occasions he had come to himself at the near approach of death.

These facts were verified by external evidence. In childhood this man had suffered from fits; evidence of only one in a later life was obtainable—at the age of 19.

5. THYROID PSYCHOSES AND THEIR RELATIONSHIPS

The physical symptoms of myxœdema are well known. The chief mental features are general retardation of mentation, lethargy, and impairment of attention resulting in amnesia for recent events.

Cretins show varying degrees of intellectual defect analogous to cerebropathic idiots, as well as characteristic physical signs.

Exophthalmic goitre is richer in mental pictures. The subjects of Grave's disease may be said to enjoy a special temperament (or is it that persons of such type develop Grave's disease ?). They are irritable, easily angered, egotistical, wilful and domineering—in their more comfortable periods—and subject to attacks of apprehension associated with the crises of their disease.

In worse cases this state of fear persists more or less permanently in a less marked form, and occasionally phobias similar to those of psychasthenia are present.

Grave's disease frequently follows psychical traumatism, either acute, such as fright and sudden bad news, or subacute, such as prolonged stress or worry.

It is important to bear in mind in this connexion that neurasthenia (anxiety type) or amentia following these causes may leave a condition of exophthalmic goitre in its wake. On the other hand, early stages of Grave's disease often present symptoms indistinguishable from such neurasthenia, and severe cases of the latter are sometimes subject to transitory attacks of tachycardia and exophthalmos. This is often seen in shell shock anxiety neuroses.

In fact the relationship of anxiety neurasthenia to Grave's disease is perhaps much closer than is usually recognized. This relationship is seen in the similarity of exciting cause ; in the similarity of symptoms, physical and psychical, and in the co-existence and mingling of signs of the two conditions in single cases.

Acute agitated neurasthenics present a picture of fear, both in physical signs and mental symptoms ; the subjects of Grave's disease exhibit practically identical features, with exophthalmos and thyroid enlargement added. Elevation of the upper eyelid (a physical sign of fear) is almost the rule in acute anxiety neurasthenia.

It is at least a feasible hypothesis that the two affections

are due in part to similar auto-intoxication, resulting from a related disturbance of the sympathetic system or the ductless glands—not improbably both, as they are known to be closely connected.

Persons with exophthalmic goitre would appear to be especially liable to attacks of apprehensive excitement, mania, and amentia agitata. Transitory attacks of exophthalmos with goitre have been described in cases of dementia præcox, and undoubtedly do occur fairly commonly.

Such attacks, however, are also known to occur frequently in sane young people, and there is as yet not sufficient evidence to warrant an assumption of any connexion between the psychosis and Grave's disease.

Nevertheless the close connexion between the sexual glands and the thyroid and other internal secretory glands is well recognized ; and when one reflects that some disturbance of sexual metabolism is regarded as an ætiological factor in the production of dementia præcox, occasional thyroid disturbance is not surprising.

The following case is not without interest in connexion with the association of symptoms of Grave's disease with other syndromes :

A girl of 30—always highly strung, clever, artistic, ambitious, good-hearted but egotistical—developed as the result of a severe psychical shock an acute neurasthenic condition. While she was under treatment for this an attack of amential confusion supervened, during which she was involved in a severe accident. No bones were broken, and after some weeks of hospital she was sent home, still exceedingly weak, depressed and neurasthenic. At this time there was present tachycardia and some degree of exophthalmos. After some weeks these symptoms gradually passed off and there was marked general improvement. Then followed an indiscretion

(over-exertion) accompanied by another minor psychical shock, with the immediate result that the exophthalmos and tachycardia returned. The day following she was very depressed and lachrymose, and another confusional attack supervened. The latter passed off in a few days and she gradually began to regain her strength, the exophthalmos and tachycardia disappearing *pari passu* with the neurasthenia.

After passing through a phase of hopelessness concerning her eventful recovery (urgently combated by suggestion—not hypnotic) she gradually grew fat and made an almost complete recovery, after about ten months from the original onset. Some months later while still physically well she developed an attack of hysterical excitement. No physical signs of any sort were present. She began to manifest delusions of sexual import. Subsequently she was lost sight of.

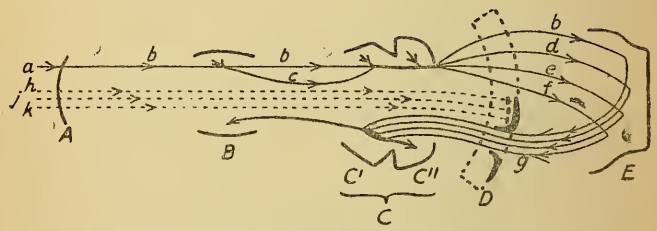
6. HYSTERIA

Hysteria is a disorder of the subconscious personality, by which is meant that complex of affective tones, instincts, tendencies, mnemonic symbols of ideas, kinæsthetic images, preconceptions, psycho-organic connexions —which is so difficult to define and delimit, but well recognized to exist and to play an important part in the constitution of the ego and the conduct of the individual.

According to the view advocated here the basis of the disorder is a hyper-excitability of the subconscious instinctive ego. Two manifestations of hysteria may be recognized clinically; the hysterical temperament, and the episodic attacks. Both are too well known to call for description.

The temperament, like all other "abnormal" tempera-

ments, varies in intensity in different persons, and shades off by imperceptible gradations into the normal. It is regarded as due to a chronic hyperexcitability of the subconscious instinctive self, often directly inherent, indicating an excessive liability to hysterical episodes. This liability being a question of degree as compared with apparently normal persons, it is likely that the latter may be capable of developing it temporarily or permanently as the result of external stimuli. It is found that causes of emotional upheaval in persons previously manifesting no hysterical temperament can result in hysterical episodes; such episodes are, however, naturally more easily produced in obviously hysterical people. The mechanism at work in the production of hysterical somatic episodes (*e.g.*, anæsthesia, paralysis, etc.) according to the theory enunciated above—the over excitability of the instinctive subconscious in hysteria—is as follows:



A. LOWER SENSORI MOTOR AREAS B. VASO-MOTOR AND SYMPATHETIC SYSTEMS
C. SUBCONSCIOUS EGO, INCLUDING C', MNEMONIC SYMBOLS ETC. C'' INSTINCTS ETC.
D. CENSURE E. CONSCIOUSNESS, JUDGMENT, WILL, HIGHER CONTROL.

[1]A sensory stimulus (*a*) with its kinetic tendency is received by the sensori-motor areas (A), from which it travels as a potential sensation

Only powerful stimuli are germane to this subject. The diagram is of course only a simple psychological picture of a complicated process. Such questions as to whether sensation, perception, etc., occur in consciousness before interaction of the results of the stimulus with the instincts and vaso-motor systems, etc., are immaterial to the thesis of this section.

(*b*) with a kinetic tendency to (B) the vaso-motor and sympathetic systems, where organic reactions occur and add to it a potential affective tone (*c*). By means of psycho-organic connexions the subconscious ego is reached, and here (C) interactions occur between the potential affective tone with its kinetic tendency on the one hand, and the instincts on the other; and by association subconscious symbols of ideas, associated experiences, and their affective tones, are aroused. Instincts consist of inherent kinetic tendencies with affective tones, and if the potential affective tone of the stimulus is out of harmony with the instincts, the resultant of the interaction is a potential unpleasant affective tone (*d*) and an instinctive tendency to action (*e*) accompanying the potential sensation (*b*) and the aroused associated mnemonic symbols (*f*) to consciousness (E).

If consciousness as the result of a stimulus experiences an unpleasant affective tone, it will also experience a tendency to action in relation thereto. At the same time sensation, perception, cognition, etc., take place.

Now three courses are open to the conscious higher control. One is to act in accordance with the instinctive tendency to action, thus dissipating the unpleasant affective tone. Such is instinctive action. The second is to admit the unpleasant tone and the natural tendency to action. To decide if such action conflicts with the higher judgment, principles or environment, and if so, to recognize the antagonism, and act in opposition to the tendency, tolerating the unpleasant tone until such time as it can be sublimated in action that does not conflict with the higher judgment, etc. The third is to suppress the whole resultant of the original stimulus (the complex) into the subconscious. This last method again would be employed as an alternative to instinctive action where the latter conflicted with the higher personality or environment. The normal healthy procedure where such was the case would be the second method, but certain individuals, notably persons of hysterical temperament, almost invariably suppress at once the unpleasant complex. Hysterical people do so because they are intolerant of unpleasant affective tones, owing

to their emotional exaltation; such tones would tend to overflow as inimical emotions. The more severe the emotional tone, therefore, the greater the tendency to suppress it if instinctive dissipation is forbidden.

The next step in the mechanism then is the suppression into the subconscious of the complex. This suppression is originally conscious, but becomes subconscious when it is accomplished, though still liable to become conscious at times. Eventually in many cases the original conscious suppression is forgotten and the inhibition remains completely upon the subconscious plane until it is strongly antagonized or broken through by further stimuli.

The psychological agent of this suppression once achieved is called the censure. It is not unlikely that the censure is always subconsciously at work in maintaining a partial inhibition of the reactions of afferent stimuli to consciousness, just as in the neurological sphere the upper motor segment exercises an inhibitive action upon the lower.

It should be made clear that the censure is a normal, not an hysterical, mechanism; also that suppression is not necessarily an hysterical act. But the suppression being accomplished and maintained, the mechanisms of hysteria come into play; the over excitable subconscious instinctive quota is further excited and stimulated by the suppression. The instinct already and always hyperexcited, thus thwarted of expression in action, is reinforced by the kinetic tendency of the complex and tends to overflow violently into consciousness once more. In response the censure acts strongly, and (as is often the case in physiology) undue stimulus results in overaction; not only is the complex prevented from reaching consciousness, but other afferent stimuli as well.

If this overaction on the part of the censure be very pronounced, inhibition of the results of stimuli in their passage to consciousness from many areas of sensation occurs, and the hysterical states of dissociation of consciousness (somnambulism, automatism, stupor) supervene. Less wide overaction of the censure results in cutting off from consciousness of kinæsthetic images through the inhibition of muscular and other afferent necessary stimuli, and hence in paralyses. Similar inhibition of sensory peripheral stimuli produces anæsthesias (*vide h. j. k*, afferent stimuli from part involved by somatic episode). The close association of the sympathetic and vaso-motor systems with affective tones and emotions is well known. It is not surprising therefore to find that the powerful instinctive affective tone of the suppressed complex in hysteria often disturbs those systems. Since instincts possess an affective tone, and all affective tones are dependent upon vaso-motor and sympathetic reactions, it will be obvious that hyperexcitability of the instincts must necessarily involve hyperexcitability of those systems. This being the case it is possible that vaso-motor somatic episodes are produced as follows :— The unpleasant affective tone resulting from the original stimulus, prior to suppression, is in part due to the contractive power upon the peripheral vessels of the vaso-motor centre. (It has been shown that such contraction occurs in unpleasant affective states.) The centre tends to gradually relax this undue contraction either with the removal of the stimulus and hence the affective tone or with the dissipation of the latter by instinctive action. In any case the relaxation would be gradual. When suppression occurs, however, the centre is suddenly called upon to relax without either of the normal stimuli to relaxation. Being already overexcitable it relaxes its tension irregularly and perhaps

excessively as concerns certain areas, and œdemas or hæmorrhages result.

Whether such an hypothesis of the actual pathogenesis of such vascular episodes is regarded as reasonable or not, the close connexion between hyperexcitability of the subconscious instinctive ego and a hyperexcitability of the vaso-motor and sympathetic systems will be apparent.

The actual site of hysterical somatic episodes is probably determined by the associations aroused amongst the subconscious mnemonic symbols by the stimulus, often images of previous slight injuries to the part involved in the episode, or as the result of disturbance of the cœnesthesis arising from abnormal stimuli from the part.

The episodes serve in some degree to satisfy the instinct which is thwarted by the suppression. In some cases the instinct involved is easily apparent, *e. g.*, when a soldier on active service develops a paralysis. The presence of epigastric anæsthesia is probably explained by the fact that fear complexes are associated with unpleasant epigastric sensations. Pressure over the epigastrium in these cases may bring about fits or emotional crises. Cases in which ovarian pressure causes these storms are probably of sexual origin.

Failure of suppression is due to stimuli causing subconscious association with the suppressed complex, and as a result of this association a summation of stimuli occurs ; the kinetic tendency of the stimuli is added to that of the suppressed complex, the censure is broken through, and the complex thus reinforced reaches consciousness once more with added tendency to instinctive action and a more intense affective tone. Emotions, crises or fits may then result—and incidentally, the temporary or permanent cure of the somatic episode, accord-

ing to the fashion in which the higher control treats the revived complex. The breaking down of the inhibition of the censure by summation of stimuli is the basis of methods directed towards the cure of somatic episodes. Hypnotism, partial anæsthesia with suggestion, and psycho-analysis are simply methods of applying the stimulus to the subconscious. The stronger the stimulus the more likely is it to be effective, and the strength of a stimulus being dependent upon its potential affective tone, it follows that one productive of emotion is most efficacious. Dreams by association and from their affective tones, occasionally cure hysterical episodes. Dreams are in fact more or less disguised fulfilments of thwarted instincts ; the affective tone and tendency to action of the suppressed complex are more or less satisfied, and therefore the episode disappears. The only difference between cure by dream and cure by psycho-therapeusis is that in the former case the summating stimulus is immediately of internal origin.

One would expect that association should occur most readily between the suppressed complex and the resultants of the curative stimulus when the latter affected the instinct involved in the suppression. This is in fact found to be the case. Stimuli productive of fear cure episodes due to suppression of self-preservation complexes ; those causing shame, etc., episodes of sexual origin. Very severe stimuli however may cure episodes by overflow association whatever the instinct affected by the suppression.

Hypnotic suggestion produces an artificial dream in which the stimuli that summate are supplied by the physician. The suggestible part of the ego is the subconscious ; an overexcitability of this (according to our theory) therefore explains the remarkable suggestibility of hysterics. Persons undergoing psycho-analysis are

partially hypnotized by the process; the physician supplies stimuli tending to produce an affective state associated with the suppressed complex which is thereby reinforced and breaks the censure.

Hysterical somatic episodes due to isolated and not continuous stimuli tend to spontaneous cure in course of time, just as a normal man is able to contemplate after the lapse of time, without unpleasant affective tone, the memory of past unhappy incidents. So in hysteria the mnemonic images of the suppressed complex are able to become memories because the affective tone has faded away; the censure letting them through to consciousness, the episode disappears. The mechanism of sex hysterical episodes differs only from that of fear episodes in that the stimuli producing them arise more or less solely from within (*i. e.*, from the sexual organs), and are more or less continual. Some persons of great hyperexcitability of this instinct develop episodes without any special external experience necessitating suppression; the sexual complexes are suppressed without such. The reason for this suppression is to be looked for in early training. Stimuli, whether external or internal, tending to reinforce the sexual instinct would first reach consciousness with a pleasant affective tone, therefore even persons of hysterical temperament would feel no impulse to suppress. The complex even if environment forbade immediate satisfaction of the instinctive tendency, would remain conscious, because it was pleasant, until it could be sublimated or satisfied. Early training however in these matters is almost invariably directed towards the suppression of the sexual instinct, not its consideration and sublimation. That is to say young people are taught to suppress the instinctive complexes. Their subsequent reappearance in gradually increasing insistence therefore is really a failure of suppression, a breakage of the censure,

and is in consequence accompanied by an unpleasant tone. The hysteric therefore suppresses the whole complex again, and if his excitability is sufficiently pronounced episodes occur in the ordinary way. Persons of less marked hysterical temperament may need powerful external stimuli, such as disappointment in love, to bring about episodes. Hysterical episodes due to sexual suppression without any particular external stimulus, tend only to disappear, spontaneously, with the decay of the instinct.

Two factors then, to sum up, are necessary for the development of hysterical somatic episodes, suppression of complexes and a hyperexcitability of the subconscious instinctive ego. It will be seen moreover that the two factors are interdependent. The emotionalism resulting from the hyperexcitability involving the vaso-motor and sympathetic systems, renders unpleasant affective states intolerable, hence they are suppressed at once. The suppression again increases the excitability, and a vicious circle is only prevented from continuation *ad infinitum* by the development of instinctive compromises, viz. somatic episodes.

It is a well-known clinical fact that conscious continual conflict with its accompanying distress does not cause hysterical episodes, but other neuro-psychoses. Nevertheless suppression does play a part in the ætiology of other conditions than hysteria. Although it is necessary for the production of the hysterical episode, alone it is not sufficient. The other necessary factor that is here suggested is an hyperexcitability of the subconscious instinctive ego.

In conclusion, it will be interesting to study a common type of shell-shock in the light of this theory.

The exact pathogenesis of total unconsciousness resulting from trauma to the head or atmospheric concussion is

obscure. It is uncertain if the unconsciousness is associated with complete inhibition of both the conscious and subconscious mind, or with complete inhibition by the censure of all afferent stimuli to consciousness. Hysteria resulting from psychical shock not producing unconsciousness is of course easily explained by the hypothesis enunciated above. Why some shell shock cases develop hysteria and others do not, is not yet determined. Probably a considerable proportion of soldiers in action have of necessity to suppress the fear complex, because it is too insistent and severe under certain war conditions to be contemplated, lest its kinetic tendency should become too strong or its affective tone cause the anxiety neurosis and physical signs of fear. Sublimation is difficult as anger and retaliation in trench warfare except when the men "go over the top," or in the case of officers in the responsible distribution of affairs. Probably the relative rarity of somatic episodes in officers is due to their continual sublimation thus.

One explanation (why hysteria occurs inconstantly in shell shock) is that it is possible for a normal person, as the result of continually or repeatedly suppressed severe emotional complexes, to develop the hyperexcitability which constitutes the hysterical temperament; somatic episodes would then result from any special stimulus *e. g.*, physical or psychical trauma.

In favour of this hypothesis is the fact that such trauma seldom if ever produces somatic episodes in civil life, except in the case of recognized hysterics.

This supposition involves the presumption that soldiers who develop hysteria after shell shock have been subjected to greater strain involving more pronounced suppression.

The other theory is that shell shock hysteria only occurs in soldiers of inherently hysterical temperament. Such a supposition in view of the absence of all history of pre-

war hysteria hardly seems justifiable, but it must be borne in mind that the hysterical temperament only differs from the normal by imperceptible gradations. It should also be remembered that a large number of people of so-called hysterical temperament in civil life, especially women, never develop somatic episodes at all.

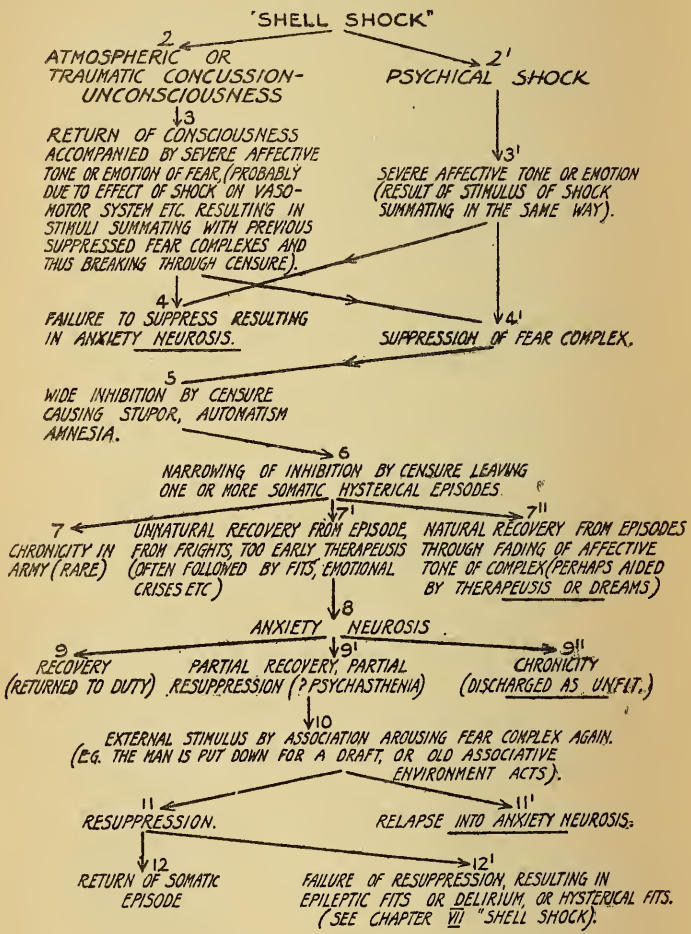
Briefly outlined on p. 146 will be found a very common case of shell shock with hysteria (together with explanations according to the theory I have endeavoured to explain), in the form of a table, A.

The numerals refer to the incidents as they arise chronologically in the course of the affection, those distinguished by added strokes indicating alternative conditions :—

Finally, the theory of the hyperexcitability of the instinctive subconscious in hysteria can be explained also in terms of neurons, that is to say, a neurological description of the mechanism of the production of hysterical episodes is possible under this theory and in accordance with neuronic theories. Four sets of neurons represent the four stations in the diagram on p. 147 these neurons being regarded as the physical basis of the functions exhibited. They are separated by synapses, one of which represents the censure. Beginning at the suppression; A strong current of nervous energy is transmitted by the neurons (E) (physical basis of consciousness), via their axons, across the synapse (D) to the dendrons of the neurons (C) (subconscious ego). This transmission occurs according to neuronic laws (actually, of course, theories), *i. e.*, simultaneously with the passage of energy down E's axons, occurs the retraction of the gemmules on its dendrons, thus cutting off partially and transitorily from E (consciousness) the afferent impulses it would receive via its dendrons from the axons of the neurons C (the subconscious). The neurons C are therefore surcharged with energy and with

neurin, but in the case of normal individuals, such surcharge, although denied escape through C's axon to E via

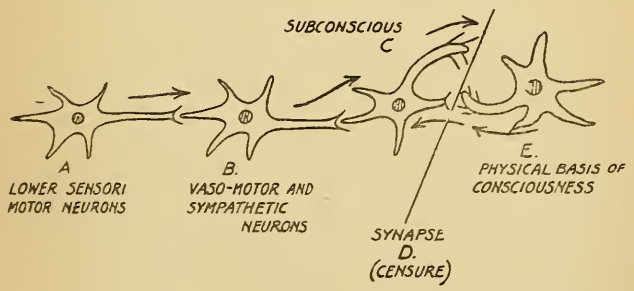
TABLE A.



its gemmules retracted as the result of the continual efferent current through the axon of E, is not sufficient

to disorder the relationships between C and E. But if the neurons C are already hyperexcitable, *i.e.*, surcharged with neurin, their most powerful attempts to discharge their energy are met by still more powerful, undue, and irregular efferent action of the neurons E. (Over-action to stimuli.) Other gemmules of E therefore normally receiving afferent muscular, sensory, etc., peripheral stimuli are more or less permanently retracted and the hysterical somatic episode results. Other effects may also occur from the penning up of neurin in excess within the neurons C, viz. disturbance of the free afferent flow from B, and hence the supervention of vaso-motor episodes.

Further afferent stimuli to the neurons C increase the surcharge of neurin, and a further comparison in power of energy, afferent and efferent respectively, as regards E, occurs. Should the former be stronger than the latter, discharge via C's axon to E occurs, the synoptic resistance at D (the censure) being overcome, and the complex reaches consciousness through this summation of stimuli, thus curing the episode.



7. CONSTITUTIONAL IMMORALITY

This term is used in its strict sense to describe an inherent intrinsic anomaly resulting in continual and excessive

infraction of generally recognized moral laws on the part of a person manifesting no intellectual abnormality nor any other sign of imbecility or psychosis.

Probably this well-defined conception of a special anomaly is erroneous ; at any rate there is little evidence to be adduced in its support.

It will be noted that in order to be covered by this definition, criminals and immoral persons must manifest excessive deviations from the moral code in the direction of repetition and monstrosity. And this proviso gives away the whole theory of a sharply defined anomaly of purely moral nature. What criteria are to be available to enable the line to be drawn between the degrees of immorality, or of the loss of control or lack of altruism which may be ætiological factors ? We are none of us born with an equal tendency towards good or evil. Lack of moral control or deficiency of altruism may be the product of psychopathic inheritance, as well as circumstance, doubtless, but there is little justification for the view that these deficiencies alone (themselves relative) constitute a psychopathic state, let alone an inherent " degenerative anomaly." Would one dare to diagnose any psychopathic state or anomaly from the relative lack of one trait only ? It may be conceded that certain individuals inherit an excessive impulsiveness of character or a degree of altruism below that of the majority of their fellows, but if this is to be regarded as of anomalous or pathological significance it should be accompanied by other signs of psychopathic inferiority. One does not diagnose ordinary imbecility from the absence of critical faculty, for example.

A large proportion of the chronic immorals and criminals do show marked signs of intellectual and emotional abnormality, and in these a psychopathic family history is common.

In ordinary criminals or insistently immoral persons who show no signs of any other deviations from the normal in conduct or personality, a psychopathic family history is no more common than in law-abiding persons. If a purely moral imbecility exists as a variety, it should be possible to demonstrate an appropriate family history. As a matter of fact in many descriptions of so-called purely moral imbeciles which one reads, other signs of obvious abnormality are recorded, and as evidence, ignored.

From the study of chronic criminals as we find them certain facts transpire.

It is found that those of the worst type are often definite psychopaths such as chronic alcoholics, imbeciles, and epileptics. Others are paranoiacs, hypomaniacs, paralytics (not usually sinners of long standing) slowly developing cases of dementia præcox, or normal blackguards. In passing, it may be said that Lombroso's identification of constitutional criminality with epilepsy is untenable in the light of modern knowledge. To sum up, then, the theory of the specially anomalous nature of chronic immorality apart from other deviations from the normal, is not only unproved but improbable.

One word concerning the treatment of cases of chronic immorality and crime. Psychological and medical treatment there is none of any avail. Hypnotism with suggestion can sometimes temporarily cure a special case, but it cannot change the character of a chronic criminal—the vice will recur or merely change its form, because nothing is supplied in its place. Prisons, moral teaching, logical reasoning, and environment are often perfectly useless. Criminal conduct, though becoming a habit, is a subconscious struggle of the individual for happiness—an illicit expression of an instinct present in all men. It is quite useless to take away the means of

expression without supplying the want which has given rise to them. To change a chronic criminal into a good citizen, it is necessary for him to be "converted," that is to say, for some great upheaval of his personality to take place. This has quite commonly been brought about. The exact pathogenesis (if such a word may be pardoned) of the process is unknown, but the ætiology is perfectly apparent, viz. first-hand religion. Those who are interested in this subject, one of some importance to the alienist, should get into touch with some live slum-working religious organization, such as the Salvation Army, not with its social organizing work, but its evangelical missions in squalid districts.

CHAPTER VII

SHELL SHOCK (*See also* "HYSTERIA," p. 146, *Table A, for psychology of Shell Shock.*)

(INCLUDING BATTLE-STRAIN, ETC.)

THE notes recorded under this title are at present of necessity somewhat fragmentary. There is as yet no co-ordinated literature available. Each observer relates his own experience; and that of the present writer, concerning cases that have been invalided home, many of them relapses, or first attacks arising after invaliding for some other affection, may not be devoid of interest. The cases that I have seen were those from the Eastern Command Depôt, Shoreham, the London Command Depôt, Seaford, as well as those from ordinary regimental depôts, etc., situated in the Eastern Command, and direct Expeditionary cases off convoys.

The term shell-shock involves no definition, but is used to cover practically all nervous and mental manifestations (and also their generic cause) arising as the result of the circumstances of battle. It embraces in the ætiological sense at least four main factors, any or all of which appear to play a part in the production of nervous or mental syndromes :—

1. Physical trauma applied to the head.

2. Atmospheric concussion following large explosions in the near vicinity. There is probably (apart from gross injury) no essential difference in the effects of these two causes.

3. Psychical strain, prolonged, sudden, or both.

4. Injuries in regions other than the central nervous system.

5. Neuropathic inheritance.

With regard to immediate effects, the following suggestions appear to be fairly well established.

The first two factors usually result in immediate unconsciousness, which may be followed (and occasionally replaced in less severe cases) by other manifestations, *e. g.*, mental confusion, amnesia, stupor, etc.

The third factor would appear not to be followed by unconsciousness (fainting from fright being excluded). Prolonged steady strain usually results in asthenic pictures of neurasthenia ; sudden intense strain, in acute mental disturbances (*e. g.*, amentia), amnesia, acute agitated neurasthenia (anxiety neurosis), hyste ical dumbness, etc., fits, automatism, and partial unconsciousness.

The fourth cause is seldom operative in the production of immediate nervous or psychical disorder, but later secondary manifestations, though rare, do occur in some cases. Probably the wound has no connexion with the shell-shock, except that it may later on determine the seat of an hysterical somatic episode. (*See* Hysteria.)

Marked neuropathic inheritance or acquired (pre-war) instability is not found in many cases other than those of neurasthenia resulting from general steady strain, such being sufficient as a rule to cause a breakdown in these men.

Of course, the difficulty of the whole question is that the vast majority of cases—at all events the severe types—have been subjected to many or all of the above factors.

In some cases (apart from unconsciousness resulting from causes 1 and 2) there is a considerable latent period before the development of any marked nervous symptoms

at all, and this delayed onset is not confined to wounded men.

A common history of cases of shell-shock is as follows :

After being " blown up " in some degree, or following psychical strain, the man acquires some immediate psychical or nervous symptoms and is sent into hospital. Having made a fairly good recovery, he is sent on leave, and subsequently rejoins a regimental or command depôt. After a lapse of some weeks or months, he again breaks down, often with symptoms materially differing from those for which he was originally invalided.

Another class of case is that in which the man has " gone sick " with an ordinary medical or surgical illness, and develops " shell-shock " after recovery from the illness.

Of the cases that break down with shell-shock at the Front and completely recover without being sent home, I have no personal experience.

Finally, there is the man who develops shell-shock at the front, is sent home, and never recovers at all, at all events in the Service.

The latter is an important practical point. Unfortunately, the shell-shocked soldier is kept in military hospitals and convalescent homes for months, in the hope that he will recover, and not infrequently eventually invalided out of the Service as unfit ; when if he were sent home to his people, after the subsidence of acute symptoms, say in a couple of weeks, he would recover a thousand times more rapidly, and subsequently be quite fit for some form of military service. What these cases need (I am not of course referring to lunatics) are their homes and families for two or three months, then a convalescent home, and finally a Command Depôt. These observations are especially applicable to the fright and strain types, *e.g.*, neurasthenia of all sorts,

depressed cases, etc., to whom military hospitals are often positively harmful. Acquired neurasthenia with agitation and depression (anxiety neurosis) in civil life is only curable by removing the patient for a while—in some cases permanently—from the environment in which it arose. The Army is the cause of shell-shock, and these men should be removed from all its influences for a considerable period. If they relapse seriously when they rejoin they will never be any use in it again, and never would have been. This analogy with civilian cases merely strengthens the conclusions arrived at from experience of soldiers suffering from shell-shock, in a great many of whom the syndromes of neurasthenia (both forms), psychasthenia, emotional depression, and apprehension of neurasthenic origin, are the most intractable and prominent features.

There are no statistics of which I am aware to show the percentage of cases of shell-shock that relapse, or who develop after a latent period nervous symptoms following bodily illness, or psychopathic and neurotic manifestations differing from the original shell-shock—but it must be a high one.

It is mainly with these similar and dissimilar relapses that these present notes will deal.

The following cases taken at random from those who have passed through my hands are fairly typical. Comments on them will be made subsequently. The events in the cases are recorded chronologically:

Case 1.—Atmospheric concussion from shell explosion, October, 1915, followed by unconsciousness.

Blindness for a month immediately following recovery of consciousness; "neurasthenia" (anxiety neurosis) after return of sight; partial recovery (*i.e.*, apparently nearly complete recovery); latent period of a few weeks: return of blindness in one eye (December);

five days' automatic wandering (hysterical) (the man was found in a west country town five days after leaving home to rejoin Depôt and seen by an R.A.M.C. M.O. who reported that he was dazed and amnesic for that period); admission to 2nd E. G. Hospital, December 15. On admission was found to be suffering from minor hysterical symptoms, *e.g.*, inability to open his eyes, and to see clearly when the lids were raised. These symptoms rapidly cleared up under suggestive conversation, and did not return. Except for anæmia and slight emotional depression, he remained well until December 25. On that day began for the first time to have definite epileptic fits and nocturnal epileptic delirium. In January was discharged as an epileptic. There was no epileptic temperament or feeble-mindedness. Finally, there had never been any personal or family neuropathic or psychopathic history.

Case 2.—Shell-concussion ("blown up," precise nature unknown), April, 1915, followed by unconsciousness; subsequently asthenic neurasthenia, pains in head, and slight amnesia. Admitted to 2nd E. General in January, 1916. On admission was semi-conscious, stupefied, confused, and disorientated, having no idea even of the general nature of his surroundings or companions. He was not apprehensive; hallucination seemed to be, and flight of ideas was, absent. He appeared anxious in a dull sort of way, continually expecting "a sailor with a card." His mind ran on this topic alone, and his speech, though fragmentary and infrequent, was perfectly intelligible and showed his evident train of thought. He gave no replies when questioned, but obeyed such simple commands as he could understand. He appeared to be amnesic, and his mental action was obviously slow and laboured. In short, his condition was almost a typical epileptic confusional attack.

Three days later he emerged from his delirium, and except for amnesia for the attack and some degree of general mental retardation, remained normal until transferred. No signs of the epileptic temperament were manifest. Personal and family history negative.

Case 3.—Delirium due to strain of action: "neurasthenia" followed: apparently complete recovery (that is, latent period) for three months. Then epileptic fits supervened. There were no signs of the epileptic temperament. Physical and family psychopathic history negative.

Case 4.—Buried in mine explosion, October, 1915. Subsequent unconsciousness or semi-conscious for several days. After recovery from that, was "neurasthenic" and exhibited functional deafness and stammer. Then followed actual mutism for several weeks. Next the dumbness disappeared, and epileptic fits supervened.

On admission, he was in a waking-dream-like condition (hysterical), completely disorientated, inaccessible, and anæsthetic to pin-pricks. He lay in bed dumb, with a grave awe-struck expression on his face, watching and following with his finger the flight of hallucinatory aeroplanes. Flexibilitas cerea was pronounced. There was no oppressive stupefaction. The following day he had emerged and merely manifested some slowness in mental action, disorientation in time, complete amnesia from the attack, and some defect of associative memory. The stammer had returned. The day after that, only amnesia for the attack remained. Finally he began once more to have epileptic fits. The man's previous history was important. Thirteen years ago he had a fit for the first time in his life, and since had had a few more. Seven years ago he had suffered from "a stroke," and it was found that slight hemiplegia was still present.

Case 5.—Wounded in leg, and several months afterwards developed "neurasthenia," followed by complete recovery. A latent period of about three months occurred next, at the end of this epileptic fits supervened, and the man was discharged. No epileptic temperament or equivalents were observed. Previous history and family history were negative.

Case 6.—Atmospheric shell concussion, November, 1915; not followed by unconsciousness, but a few hours afterwards by automatism—succeeded by amnesia. Subsequently was "neurasthenic" for some months. Apparent recovery followed until March, 1916, when epileptic fits began. No epileptic temperament. No psychopathic history.

Case 7.—"Blown up" by a bomb and became unconscious. Acute anxiety neurosis followed, from which, after five months in various hospitals, the man never recovered while in the Service. Personal history of timidity and psychasthenia.

Case 8.—Severe wound in back; bullet eventually located and removed two months afterwards. Five months after wound, developed nocturnal delirium. Three weeks later a typical attack of epileptic confusion lasting about a week. This began by an explosion of temper and violence, succeeded by a picture of slow stupefied confusion and depression, with vindictiveness and ideas of ill-usage alternating with tears. Amnesia for incidents of attack remained. Subsequently more or less periodical depression of short duration, causeless and unaccompanied by neurasthenic signs, manifested itself. A definite epileptic temperament was present. The former history revealed night-terrors in childhood, occasional nocturnal tongue-biting in adult life, but no known fits.

The above examples, though individual cases, are

types, many essentially similar having been seen. Simple cases of asthenic neurasthenia without mental anxiety or hysterical symptoms were seldom admitted to my wards.

In the types of cases illustrated by the above examples, certain interesting features are to be observed.

1. The first point that strikes one is the frequent development of epileptic fits or equivalents in cases of severe shell-shock.

2. The next is the fact that in many cases a latent period of apparent health, varying from a few weeks to several months, preceded the development of the fits.

3. The intermixture and succession of hysterical, neurasthenic anxiety and epileptic features in a single case is very common, in fact almost the rule.

4. The absence in nine out of ten of these shell-shock epilepsies of the epileptic temperament.

The following comments upon these four observations are intended to be suggestions, not dogmatic assertions :

1. The common incidence of epileptic fits as a result of shell-shock in persons previously showing no signs of psychopathic tendency or heredity, would appear to put the final nail in the coffin of the theory of the degenerative and inevitably hereditary nature of fits. Traumatic epileptic fits in civil life, intoxication epileptic fits, etc., were other nails. Other interesting points concerning epilepsy are also brought to light by the study of these shell-shock cases : one of which is that atmospheric concussion may apparently cause epileptic fits ; another is, that even specific shell-concussion is not essential in these cases, fits resulting in some men without any shell-explosion having occurred in their very near neighbourhood. Cases 3 and 5 illustrate these points. Examples of this class do more

than suggest that epileptic fits may result from psychical trauma alone. The theory held by the present writer, that these fits are identical in ætiology and pathogenesis with hysterical fits is discussed under "hysteria."

2. In cases of traumatic hysteria and "neurasthenia" the frequency of a latent period following the immediate shock of the trauma is well recognized, but it would appear that a period of incubation very frequently if not in every case precedes the development of fits in shell-shock epilepsy. It may be contended that masked epilepsy was in existence throughout this latent period, and even from the period immediately following the trauma, but how this contention is to be maintained in the absence of all signs, it is difficult to see. It is true that vertigo precedes the fits for some time in a few cases. But vertigo is an exceedingly common feature in shell-shock of all varieties, and in only a few is it followed by convulsions. The same observations are true of transitory muddled feelings in the head, depression, etc., and I do not think one is justified in regarding all these symptoms as epileptic manifestations. However that may be, there is a considerable residue of cases which never manifest any of these signs of masked epilepsy, if such they be, but begin ? after a period of apparent health, to suffer from fits.

In cases of physical or atmospheric concussion followed by unconsciousness, the delay in the onset of the fits may possibly be explained by the supposition of cicatrices, organization of blood-clot, etc. ; but it is not easy to see how the psychical strain epilepsies are susceptible of this explanation.

It is probable then, as suggested above, that in a case of epileptic fits instituted by psychical strain (and arguing also from analogy with traumatic hysteria) that the epileptic fit itself may be primarily a psychical

commotion differing in appearance but not in essence from the ordinary hysterical fit.

This and other hypotheses arising out of such cases must for the present remain hypotheses.

3. There is nothing remarkable in the coincidence of succession of the various neurotic and psychical results of shell-shock in a single case, when one views them in the light of the theories propounded above under "Hysteria" (*vide* p. 135 et seq.) and under "psychasthenia" (p. 128). Psychical trauma would appear to be the most potent factor in the production of all but the immediate loss of consciousness following actual concussion. Simple concussion in civil life, when it is not accompanied or followed by psychical trauma, rarely results in neuroses or psychoses or fits. It is not unlikely that where such do supervene evidence of psychopathic inferiority always pre-exists. Battle-strain, although perhaps not consciously and fully recognized, is a severe form of unhappiness. The importance of unhappiness is coming to be more and more recognized in its relation to nervous and mental health. No single cause conduces so much to the development of psychoses and neuroses. The struggle of the individual for happiness is the struggle of the individual for health, and the loss of the one involves eventually the loss of the other.

4. The absence of the epileptic temperament or character in so many of these shell-shock epilepsies, even after the fits have become well established, is interesting, and it can be interpreted in three ways. One view that may be held is that the fits have not existed long enough for the character to develop. This supposition presupposes that the temperament is the result of the fits. I know of no statistics as to the ultimate development of the temperament in the traumatic epilepsies of civil life, and our experience of shell-shock cases has not been

long enough to justify any deduction from them on this head. Nevertheless, in view of certain considerations I do not think this hypothesis is the right one. The epileptic temperament is found in persons who have not developed fits, but who subsequently do so, and also in cases of masked epilepsy without convulsions. Again one finds that in a considerable proportion of shell-shock epilepsies, which do manifest the character, evidence of the preëxistence of the latter can be obtained, and signs of masked equivalents in some cases. Why these cases should have developed the temperament as the result of fits, and the much larger number should not have done so, it is difficult to explain, if such a theory is correct.

Another explanation of the rarity of the epileptic temperament in shell-shock epileptic fits is that the temperament is inherent.

The present writer regards it simply as a special variety of psychopathic inheritance indicating a strong predisposition to the development of fits and equivalents. Persons of epileptic temperament, in other words, have a psychopathic family history, often dissimilar in type, but the temperament and its accompanying tendencies shades off into the normal in different individuals. The well-marked cases usually develop fits, the less marked, often masked equivalents—both more or less spontaneously. Considerable emotional upheaval or physical trauma causing organic lesions or toxic infection is necessary to the production of fits in persons without perceptible epileptic temperament. It is not unlikely that the temperament is also an essential factor in the development of all "insane" epileptics, that is to say those in whom psychical equivalents are pronounced and in whom dementia develops. It is well known in the case of epileptic feeble-minded-

ness that its intensity is dependent upon the age incidence of the fits, and naturally one would expect those persons with a marked predisposition thereto to develop the fits early in life. This suggestion explains also why the temperament is in fact found most marked in chronic convulsive cases. Probably, however, the traits in the character are intensified by the inequality of the struggle for existence to which severe types are subjected, as compared with those less seriously affected and the normal; moreover the patient's control and judgment are weakened by the progress of the feeble-mindedness, hence the traits of the temperament are less concealed.

The third view is that the epileptic temperament is absent because the fits in shell-shock are in origin hysterical.

A great deal that we have learnt from the results of shell-shock was previously known in association with other traumatic causes, and in concluding these brief notes it will be as well to quote in abridged fashion from a standard author :[1]

" . . . A fairly typical series of traumatic insanities is now known, having as a common feature impairment of the memory and character. The various clinical pictures that result, more especially in cases in which the trauma has affected the head, are as follows :

" 1. Ephemeral or partial disturbances immediately succeeding the traumatism, such as loss of consciousness together with anterograde and retrograde amnesia.

" 2. Chronic psychoses (chiefly hysterical in nature) after a latent period and which are rarely recovered from.

" 3. Special and irreparable perversions of character.

" 4. Reflex psychoses, hypochondria, mono-hysteria and epilepsy consequent upon compression and irritation

[1] Tanzi, *Text Book of Mental Diseases*, 1909.

of the nerve tracts or upon trauma affecting other parts of the body than the head and brain."

I think we have got a little farther than this summary. Considerations of space preclude lengthy criticism here—it is left to the reader—but one would appear to be justified in saying that the terms "insanity" and "psychoses" at least are used rather too loosely.

. . . . .

With regard to the association of other mental disorders with the causes of shell-shock, it may be said that ordinary mental affections would appear to be uncommon amongst delayed or relapsed syndromes. They are, I believe, more common at the Front, and take the usual form of amentia, mania, and melancholia. Of those of delayed onset the most frequent to appear is dementia præcox, probably owing to the relative youth of the majority of our soldiers (until recently). Melancholia and confusional attacks sometimes supervene upon active service "neurasthenia" (combined type).

To sum up, the present writer regards the following conclusions drawn from the study of shell-shock as provisionally accurate. Agitated neurasthenia (anxiety neurosis) in these cases is due to continued or repeated conscious conflict between the fear complex and environment or higher control, and is accompanied by a process of auto-intoxication. It may or may not have been preceded by hysterical episodes, but previous suppression of the complex has always preceded its development. The neurosis is likely to be more severe where the environment tends to necessitate further attempts at suppression of the fear complex, which fail. Persons who are constitutionally fearful in temperament (psychasthenics) more readily develop the anxiety neurosis.

Suppression of the fear complex in persons of hysterical temperament (probably existing in previously normal

persons after continued and repeated suppression) results in hysterical "stupor," automatism, or somatic episodes.

Fits occurring after a latent period, which have never been preceded by any signs of epilepsy prior to the shell shock, and which are not accompanied by the epileptic temperament or due to gross injuries to the skull, are the result of sudden transitory and violent failure of suppression of the fear complex, and are essentially hysterical in mechanism whatever their clinical character may be.

" Epileptic " delirium in these cases is of similar nature to hysterical delirium.

There would appear to be two distinct forms of epileptic fits, apart from those due to organic irritative cerebral lesions—distinct, that is, in ætiology and mechanism of production.

1. True idiopathic epilepsy accompanied by the epileptic temperament, and tending to dementia. A family history of insanity or epilepsy is forthcoming in these cases, and they are usually incurable.

There are of course, owing to the fact that the epileptic temperament shades off into the normal in different persons, grades of tendency to idiopathic fits. These grades would account for temporary epilepsy due to metabolic disturbances, rickets, teething, trauma not involving continued organic irritation, etc.

2. Epileptic fits of hysterical origin unaccompanied by the epileptic temperament, and not tending to dementia in their subjects. In them no history of insanity or epilepsy in the family is obtainable, and they are sometimes, probably, if pure cases, always curable.

It will be easily seen that fits of combined origin may occur, the hysterical mechanism of suppression and hyperexcitability, acting as an exciting cause to some degree of epileptic temperament. This is probably

the explanation of occasional chronicity in fits of shell-shocked soldiers after discharge from the Army, and probably also of fright, etc., epilepsy in civil life, but it it is also probable that continual repetition of fits of hysterical origin may terminate under unfavourable conditions in chronic epileptic fits as the result of cerebral habit, in the case of persons never perceptibly of epileptic temperament. With regard to clinical distinctions between the two varieties of individual epileptic fits, it may be said at once that there does not appear to be any in a considerable number of cases.

The distinctions between typical hysterical (old classical type) convulsions and typical epileptic fits, are of course well known. In the post-convulsive or equivalent hysterical states of delirium there is this distinction from those of chronic epilepsy, namely the patient is not so stupefied, his mental action is more rapid, and he is more accessible to external stimuli.

True hysterical delirium apart from convulsions is marked by a complete absence of stupefaction but complete dissociation from the environment. All hysterical emotional states of dissociation being of the nature of vicarious expressions of instinct suppressed, illustrate the instinct.

Hysterical "stupor" and automatism manifest less inaccessibility and imperception than similar epileptic states.

Fits that are periodical are always at least in part due to idiopathic epilepsy.

Finally, after shell-shock, chronic epileptics not infrequently develop fits of definite hystero-epileptic type.

CHAPTER VIII

COMBINED AND ATYPICAL PSYCHOSES

The study of mixed mental disorders is as interesting as it is complex. It is as yet in its infancy, but by the record of individual cases a literature relating to the subject can be built up for subsequent students to systematize and correlate.

Several varieties have been mentioned already; in this chapter they will be supplemented, grouped together, and briefly summed up in a provisional fashion, the accuracy of the epitome so far as designation is concerned being dependent upon our present knowledge and plausible theories of classification.

Three main groups of cases present themselves for examination, viz.:

1. Combinations of anomalies with psychoses or neuroses.
2. Combinations of anomalies with anomalies.
3. Combinations of psychoses and neuroses with each other.

1. COMBINATIONS OF ANOMALIES WITH PSYCHOSES AND NEUROSES

By the term an anomalous person is meant one whose abnormality is an inherent integral part of his ego, and not an acquired disorder. Anomalies are not monstrosities—wretched individuals born outside the pale of the

rest of humanity—but simply people whose inherent deviation from the normal type is pronounced. Naturally enough their family histories are psychically more defective.

In this sense all abnormal temperaments are anomalies, and probably many of us are more or less anomalous. Is is the old question of degree of abnormality, and there is no hard and fast line to be drawn.

The conditions usually described as anomalies are paranoia, imbecility, and constitutional immorality. The paranoical temperament is a marked one and hence an " anomaly," the development of delusions in such cases being analogous to the development of fits, etc., in persons of epileptic temperament—probable, but not necessary and inevitable.

Perhaps the best conception of an anomaly is an inherent purely psychical deviation from the normal. So far as our present knowledge points, hysteria, psychasthenia and paranoia, only, would be covered by this definition.

Imbecility is more than a temperament or character, the result of deviations in degree of prominence or disorder of fully developed faculties ; it is a spontaneous arrest of development of all faculties recently acquired by man. The temperament and the character of individual imbeciles varies just as that of individual children, grown-up, uneducated varieties of which, imbeciles are. Children can be educated because they gradually develop faculties susceptible of education ; imbeciles do not. Hence the final difference in the results.

Constitutional immorality apart from imbecility has been discussed on page 147, and the view expressed there that the existence of such as a hard and fast abnormality of inherent type is not proven.

Nevertheless these three conditions, one in essence a

temperament, another an arrest of development, and the third a simple and special exaggeration of conduct, are for purposes of convenience in subdivision included in this section under the head of anomalies.

(A) ASSOCIATION OF PSYCHOSES AND NEUROSES WITH IMBECILITY

Imbeciles are more liable to attacks of psychoses than are normal persons, but the varieties of mental disorder do not materially differ in the two cases.

Perhaps the most common superimposed mental syndromes found in imbeciles are simple stupor, amential apprehensive confusional episodes, epileptic fits, hysterical episodes, and depression.

Simple stupor in imbeciles is characterized by the absence of symptoms of the specialized stupors, viz., katatonia, emotional depression, or epileptic moods and episodes, etc., and by the presence either of demonstrable signs of imbecility in slight cases of stupor, or marked intellectual alienation and apparent dementia out of all proportion to the degree of inaccessibility, in severe cases. In all cases the " demential " symptoms are much more marked in proportion to the inaccessibility than is the case in simple amentia attonita. Put more colloquially, the patients are usually without ideas or memory, lost in mind, vacant and dirty, yet quite capable of understanding ordinary commands and of appreciating the nature of individual objects. There is less general mentation than in the simple stupor of dementia præcox ; delusions, hallucinations (usually), and the self-puzzled state of dementia præcox are absent. Nevertheless in minor degrees of imbecility with stupor the distinction is often difficult.

These attacks are usually short in duration, but occasionally persist for some weeks, not infrequently with

remissions. They are not accompanied by marked cachexia even when prolonged. They are probably amential episodes of atonic variety, the divergencies from amentia attonita being due to the imbecility on the one hand and to the generally remarkably good bodily health of imbeciles on the other.

The excited amential attacks of imbeciles are also short in duration, and differ from simple agitated amentia in the same way that the stuporose attacks differ from amentia attonita, viz. : in the relatively high degree of disorder in ideation, association and reasoning, to the depth of inaccessibility. They evince ephemeral superficial and childish emotional states which betray their immaturity, and they are more degraded in conduct in relation to the depth of confusion.

In addition to these well-defined states, intermediate ones are found with a mood of hilarity and exaltation, or depression and tears, both accompanied by hallucinations and confusion, without imperception or inaccessibility. Probably these are analogous to paranoidal amentia in normal persons, the absence of delusions being due to the imbeciles' lack of imagination.

Two varieties of association between imbecility and epilepsy have been observed, but probably one of them is the result of a misconception.

In the first combination the fits are of long standing. There is a general lack of knowledge and a considerable degree of childishness both intellectually and emotionally, but replacing the alertness, rapid mental action, good memory for facts, quick perception, volatility and conceit of the imbecile, are manifest the signs of the epileptic temperament and feeble-mindedness.

In these cases one is dealing with an organic cerebropathy accompanied by epilepsy.

Theoretically it is possible for a person of epileptic

temperament and suffering from fits to be also an imbecile. Possibly some of the long standing epilepsies with childishness, fickle spitefulness and cruelty are of this mixed type.

The other type of case is that of the typical imbecile who suffers from more or less infrequent fits, arising at a later period in life. This association is probably as accidental as it is uncommon.

Imbeciles who grow up into adolescent dements (their usual method of developing dementia præcox) rapidly sink into a depth of dementia unknown in the uncomplicated psychosis, and, owing to their lifelong poverty of ideas and lack of imagination, they present a relatively colourless clinical picture. Katatonia if present usually takes the form of stereotypism of a simple variety. Neologisms, pedantry, absurd pseudo-scientific delusions, and the generally flowery but useless ideation and conversation of dementia præcox, are absent in cases where a moderate or high degree of imbecility pre-existed. Comprehension, orientation, association of ideas generally, are also more deeply affected in the combined cases.

The result is a dirty, automatically destructive, degraded and useless dement. He is a familiar figure in asylums, frequently to be perceived picking at his skin and clothes, and emitting animal-like unintelligible noises, while lurking in all the glory of a saliva-stained "strong suit" in the corner of an airing court—a pitiable picture of the degeneration of an individual to a level below that of the brutes.

Like ordinary people imbeciles are liable to attacks of mania and melancholia, but not nearly so strongly as they are to dementia præcox. Manic-depressive syndromes in imbeciles are for the most part short in duration, and characterized by an easily recognized com-

bined picture of symptoms. Chronic hypomania may also be combined with imbecility. This class of patient is to be distinguished from uncomplicated hypomania by the general futility of conduct, childishness, and lack of principle, knowledge, and imagination displayed.

Some imbeciles suffer from attacks of noisy lachrymose depression quite frequently, but the attack passes off in a day or two. Probably these are not of manic-depressive origin.

Hysterical episodes are common in imbeciles, but the more elaborate varieties are probably impossible to them. The common manifestations are fits and emotional crises.

Alcoholic syndromes in well-marked grades of imbecility would appear to be rare. This is probably in part due to the fact that imbeciles do not stand in need of artificial excitants of a subjective *bien être*. Chronic alcoholism, as well as criminal tendency, is frequently found associated with mild degrees of imbecility, but not by any means in all cases. Even imbeciles enjoy an individual personality peculiar to themselves, and though presenting certain features in common, they do not all act in the same way.

(B) PARANOIA

In the writer's experience paranoiacs with systematized delusions seldom suffer from ordinary psychoses. In badly managed asylums they occasionally develop as the result of injudicious opposition and tactless handling, a species of maniacal excitement, of a resentful, angry, reckless type, entirely devoid of the hilarity, *bonhomie* and divertibility of the maniac, and lasting a few weeks. Also as the result of the opposition of their fellows they may suffer from attacks of sullen depression, free however from indecision or self-depreciation.

It is more than doubtful if these syndromes have any relation to manic-depressive insanity.

Amentia in mature paranoiacs would appear to be rare : the same is true of alcoholic syndromes. Epileptic fits are however not so uncommon. Psychasthenia is said to be opposed to the paranoiac's temperament, and in fact it does not occur in well marked delusional cases of paranoia.

It is an attractive and not untenable hypothesis that the individual cases of ordinary psychoses which manifest a tendency to systematized delusions are in reality the result of a combination of the psychosis with a paranoical temperament (*vide* Paranoia, p. 61). Examples are, periodic mania with paranoidal delusions, alcoholic paranoia, systematized delusions in G.P.I., melancholia with delusions of persecution or chronic hypochondria, certain systematized types of dementia paranoides. These have been noticed under their appropriate headings. Some epileptics develop more or less systematized delusions of persecution, more prominent during their equivalents, but present always. It is not unlikely that these are also possessors of the paranoical temperament. The more systematized varieties of dementia paranoides mentioned above manifest in their early stages a remarkable resemblance to paranoia. The patients often relate a connected scheme of imaginary persecution extending back over a considerable period of years, unaccompanied by apathy, katatonia, mannerisms of conduct or speech, exaggerated or intrinsically impossible statements, and all the ordinary signs of dementia præcox (which are of later development). Another type of the same condition resembles the religious varieties of paranoia very closely. These coherent delusional conditions often come under the notice of the alienist when the patient is between 30 and 40 years of age, relatively early for paranoiacs

and late for adolescent dements. Whether the paranoical temperament is regarded as playing any part in their ætiology or not, the clue to their diagnosis is the coincidence, however rarely, of pseudo-hallucinations—not always easy to elicit, but conclusive when found with delusions of this nature.

The paranoical early forms of G.P.I. have been noticed and they are probably not so rare as they would appear to be. In one or two cases the writer has been able to elicit by inquiry from relatives, etc., evidences pointing to a paranoical temperament in the patient years before the onset of the G.P.I.

The paranoical temperament is said also to be opposed to the hysterical, and yet we see cases of paranoia enjoying —in states of emotional exaltation—hallucinations, trances, etc.—showing that they are capable of developing the dissociations of hysteria, just as normal persons are under stress of circumstances. In passing, it may be said that the delusions of paranoiacs are probably analogous to the dreams of hysteria, *i.e.*, disguised wish fulfilments.

Some varieties of so-called chronic neurasthenia with delusions of bodily illness are probably in part the result of a paranoical temperament, the delusion not partaking of the nature of a reaction to a subconscious fear, or an irrepressible idea, but a conviction which is welcomed by the temperament of the patient—embraced as in accordance with his tendency to preconception—and not resisted. Signs of neurasthenia may co-exist, and it is not unlikely that the temperament has been lighted up by the neurasthenia. Probably a considerable number of the motley cases labelled hypochondria are of this combined nature. Such patients do not manifest any deep depression, impediment of will or self-depreciation.

There are other classes of hypochondriacs who would appear to be combinations of melancholia with the paranoical temperament. They are depressed, obstinate, and exhibit fixed delusions of persecution (possible in type), together with some degree of self-depreciation, regarding the persecution as their just deserts. Such types usually occur after middle life and do not tend to recover.

(C) CONSTITUTIONAL IMMORALITY

Considering this condition merely as a chronic form of excessive misconduct, without any implication that it is a special inherent form of anomaly, it may be studied in its relationship to forms of psychosis (*vide* p. 147).

The subject is par excellence the province of the prison doctor, and the present writer's experience of it has been limited.

Imbecility would appear to be the most common condition associated with continual immorality, and chronic alcoholism with constant actions of criminal nature. Cases of dementia præcox in their incubation stage are not uncommonly very immoral, more rarely criminal, and probably this is the explanation of the development of this disease so frequently in juvenile prisoners. These criminal or immoral stages of adolescent dementia, without conspicuous mental symptoms, are said to be prolonged in some cases over a period of years. General paralytics in their early phases sometimes exhibit a flare-up of misconduct, but as a rule there is not much difficulty in the diagnosis ; moreover this stage is short.

The association of insistent sinning with epilepsy is probably much less general than is supposed. In fact it is commonly found—at least it has been the present writer's experience—that even demented epileptics

retain a most marked sense of right and wrong which they endeavour to live up to. Epileptics are of course prone to outbursts of rage, but it is remarkable how well they control themselves if properly handled. Unconscious or semi-conscious crimes in epileptics, the result of "equivalents," not uncommonly occur. But, and this would appear to be an important point—when an epileptic or a person of epileptic temperament is also a chronic alcoholic, not only is he prone to more frequent unconscious crimes, but being brutalized by his alcoholism, and his volition impaired, he may commit a series of crimes that are conscious and even deliberate. The following is an interesting mixed case:

T.C., aged 35, had started life in some sort of industrial school because he was destitute. After leaving that institution he embarked upon a career of petty crime terminating in a term of penal servitude for burglary. While in prison he mutilated himself and was placed under mental observation. As he was not sent to an asylum, but continued to serve his sentence, the inference is that he was not considered insane. Subsequently he joined the Army, and was in the habit of wearing the South African ribbon, to which he had no right. In the service he continually offended and malingered, and when punished became excited, truculent, and full of ideas of unjust treatment. He eventually deserted; was arrested and sentenced to twenty-eight days' detention. During his imprisonment he stabbed himself in the chest with a jack-knife, and was therefore sent to me for observation.

He was found to be a blustering threatening blackguard, almost entirely devoid of altruism, and full of ideas of grievances against his officers. He was absolutely resolved to commit suicide if sent back to serve his sentence. He was cunning and boastful, suspicious, sullen and

resentful. But in addition to all this he manifested certain features which lent considerable clinical interest to his case. There were present some degree of childish weak-mindedness with a congenital defect in articulation; liability to violent outbursts of temper with violence, periodic depression of spirits, and anomalous "fits," the nature of which I am doubtful about to this day.

After discharge from the army he falsified his discharge papers, in a silly childish fashion, represented that he had been invalided from the Front as the result of the wound (self-inflicted in fact) in his chest, by a German bayonet, and on this plea endeavoured to obtain money from charitable organizations. When the fraud was at once discovered, he mutilated himself again. Finally there was an independent history that he had been picked up in the street on two or three occasions and taken to hospital. Unfortunately no details of these incidents could be obtained. He was not a chronic alcoholic. The reading of the case formed at the time was that it was one of high grade imbecility combined with epilepsy, the incessant criminality being the result of both and also of his early environment.

2. COMBINATIONS OF ANOMALIES WITH ANOMALIES

The severest forms of psychopathic inheritance (the so-called degenerative types) are regarded as being expressed by the paranoical temperament and by imbecility, and it is not unnatural that such conditions should be occasionally found combined in one individual. Actual paranoia with systematized delusions however, precludes a co-existent imbecility of any marked degree, as considerable intelligence is necessary for the production of this systematization. For the same reason

well-marked imbeciles of paranoical temperament do not develop properly systematized delusions.

With regard to constitutional immorality (in the sense of incessant misconduct) in persons of paranoical temperament merely, it would appear to be rare. Pure cases of paranoia rarely embark upon a career of crime or immorality even when markedly delusional.

On the other hand, imbeciles are well known to be prone to wickedness, and this tendency is naturally more powerful when accompanied by paranoidal delusions, which act as additional motives for and causes of misconduct, *e.g.*, in cases with persecutory, querulent, erotic and exalted ideas. In the case of Mattoids (examples of the paranoical temperament with abortive altruistic delusions), although these persons are always slightly imbecile, they are not prone to crimes, etc., owing to the nature of their erroneous ideas. The slight imbecility present in them has not improbably prevented the complete development of systematized delusions characteristic of more fully developed types of paranoia.

Although all imbeciles are potentially immoral it must not be imagined that they invariably became so in fact. Even imbeciles have individual characters peculiar to their own ego, although they all manifest certain traits in common; and again, upbringing, environment, and opportunity are potent factors in determining the moral or immoral nature of their conduct. They are not much restrained from misconduct by principles or altruism, but by absence of inclination, or lack of the opportunity, which they are too fatuous to create for themselves.

Nevertheless the vast majority of chronic criminals show definite signs of imbecility—that is, if they show any signs of abnormality at all.

3. COMBINATIONS OF PSYCHOSES AND NEUROSES WITH EACH OTHER

(A) DEMENTIA PRÆCOX

The following are common conditions which may be found associated with dementia præcox :—

1. Neurasthenia (of both types) and psychasthenia.
2. Amential confusion.
3. Hysteria.
4. Epileptic fits.
5. Alcoholic mental symptoms.

1. Association with Neurasthenia and Psychasthenia

More or less acute neurasthenic and psychasthenic symptoms often immediately precede and usher in dementia præcox. Given a recognized case of the latter, it is of course a work of supererogation to discover neurasthenic symptoms, but in cases of neurasthenia it is of exceeding importance to recognize signs of a developing adolescent dementia. There is reason for believing that such cases can, by suitable measures, be checked and possibly aborted at this stage.

In the observation of such cases attention should be paid to the following points :—

(*a*) Ideation

The intrusion into the patient's mind of peculiar and often absurd ideas, which, instead of creating an unpleasant emotional tone of conflict and exhibiting the characteristic feature of irrepressibility (*vide* p. 124), merely puzzle the patient about himself without being recognized as pathological intruders, strongly suggests the coexistence of dementia præcox.

A further development of these ideas into audible

thought (pseudo-hallucinations) is an almost certain indication of the same affection : at any rate a conclusive proof that the patient is not merely suffering from neurasthenia. Pure cases of psycho-neurasthenia often exhibit hypochondriacal fancies due to and partaking of the nature of fears (phobias) and due in part to cœnesthetic disturbances. These are merely doubts resulting from anxiety. Fixed (not necessarily permanent) belief in the existence of special bodily diseases, in spite of assurance to the contrary by those qualified to express an opinion, indicates something more than neurasthenia, —probably in adolescents, dementia præcox.

It is hardly necessary to say that simple neurasthenia never results in obvious delusions (or hallucinations).

(*b*) Emotions

Though neurasthenics of long standing may become resigned in a dull sort of way, uncomplicated cases are never apathetic. Definite indifference in early combined cases may not, however, be very obvious. The patient may appear unstrung and agitated, but occasionally one is able to detect the first glimmerings of the causeless smile of dementia præcox. These early foreshadowings of motiveless acts do not as yet take a typical form, but are manifested by frequent and causeless smiling (smiling that is not forced, half-hearted, pathetic or hysterical), in agitated restless types, *during conversation*. It is a thorough smile, but one not excited by external stimuli to mirth, nor due to amiability. Normal individuals may have an automatic trick of frequent and thorough smiling ; agitated neurasthenics certainly have not.

With regard to the depression of neurasthenics, it may be stated that lack of autocriticism, the presence of exaggerated display or insincerity, should raise a strong suspicion of dementia præcox.

In some cases of neurasthenia there is at times a rapid fluctuation of mood in which smiles alternate with tears a dozen times during a few minutes' conversation. If these changes are spontaneous and sincere and according to the conversation they are probably hysterical; if they are automatic and of apparently internal origin, they should be carefully weighed.

(*c*) Conduct

When it is borne in mind that recent neurasthenia tends to make its subject timid, modest, and kindly, sensitive, introspective, self-distrustful, and conscientious, it will be readily recognized that any course of action directly opposed to such characteristics should give rise to grave suspicions. Neurasthenics do not act even in direct opposition to their former characters when in health, in virtue of neurasthenia alone. They have less tendency than normal persons to blatancy, vice, boasting, immodesty, cruelty, clownism, and absurd and purposeless perversity of conduct. Seclusiveness may occur in cases of simple neurasthenia and also in dementia præcox. In the former case, however, it is a concomitant of fear of society, shyness, or some special phobia: in the latter it is either motiveless or due to a *direct* and excessive *desire* for solitude. Marked seclusiveness in neurasthenic adolescents (not pubescents) becoming more accentuated with the decline of acute neurasthenic symptoms may be due to masturbation, or the onset of dementia præcox, or to psycho-analysis (!).

A moderate degree of seclusiveness in boys and girls at the period of puberty may mean nothing at all, or it may be the result of shame resulting from masturbation, or an indication of a psychopathic temperament.

Obsessive impulses to action which are yielded to have been noticed on page 126.

It should not be necessary to state that katatonia and catalepsy do not occur in uncomplicated neurasthenia.

(*d*) Pedantry in Speech

Neurasthenics who give pseudo-scientific, "highflown" or absurd explanations of their feelings should be regarded with suspicion, but in judging symptoms of this sort, especially, one must take into account the individual. If a young and characteristic farm-labourer with recent neurasthenia informed me that he thought he must be suffering from "an insufficient flow of blood to the vital organs," I should watch him narrowly for signs of dementia præcox. If a medical student made such a remark, I should ask him what the deuce he meant!

It may be said that a sudden development of pedantry in a neurasthenic savours very strongly of dementia præcox.

(*e*) Physical Signs

When neurasthenia is at all acute, whether dementia præcox be developing or not, physical signs of the former are present.

But if a young man complains (usually as the result of misguided leading questions) of feeling agitated, apprehensive, "nervy," run down, and depressed, at the time of examination, and yet manifests no dilatation of the pupils, tremors, miserable appearance, tachycardia, low tension pulse, but on the contrary looks perfectly well, cheerful and calm he is either a case of some psychosis (probably dementia præcox) or a liar.

Finally, it may be said that neurasthenia arising for the first time in adolescents without any particular or sufficient external cause, should at least engender in the mind of the medical man a determination to watch the case with great care.

In combined cases, as the disease develops so the neurosis disappears. Advanced cases of dementia præcox being emotionless are immune to neurasthenia.

One or two other points are of some importance.

Reticence in neurasthenics is uncommon. Once their confidence has been obtained—no difficult matter for a sympathetic physician—they will unburden themselves with eagerness, and are better therefor. A case of neurasthenia in an adolescent with whom it is difficult to get *en rapport* and who manifests marked reserve in his conversation, should be narrowly watched for signs of dementia præcox.

Suggestibility is an allied feature to communicativeness. Simple neurasthenics are suggestible. You cannot remove the emotional symptoms they experience as the result of the disturbance of their cœnesthesis, but you can explain their source and be believed, you can ameliorate their intensity by kind therapeutic conversation. Lack of this suggestibility is presumptive evidence of a psychosis of some sort; its exact nature will eventually, or perhaps at once, be apparent from other signs.

Neurasthenics in the acute stages puzzle about their feelings (unless they have had them before and are familiar with them), but their perplexity is accompanied by anxiety, and somatic apprehension. Self-perplexity, apart from these features, smacks of dementia præcox.

2. Association of Dementia Præcox with Confusional Episodes

The recognition of confusional intoxication conditions in known cases of dementia præcox is of academic interest only, but the reverse is the case where an attack of confusion presents itself for diagnosis in an adolescent. The common association of the two syndromes is at the onset,

or apparent onset, of the dementia præcox, and the diagnosis of the latter rests upon the observation of its special features.

In the excited varieties of confusion in these cases the amential syndrome is represented by disorientation, varying degrees of inaccessibility, restlessness, apprehension, etc., continual hallucinations, and in severe cases, imperception.

The indication of adolescent demential symptoms to be looked for are the usual characters of that disease. Signs of basic apathy can sometimes be made out, *e.g.*, conduct out of proportion to the intensity of the emotional state, periods of apathy, theatrical display, obvious insincerity, the smile of dementia præcox. Flight of ideas is not usually very marked and hence the speech is not so much disintegrated as meaningless and absurd in the mixed types; it may be infrequent, and occasionally, entirely absent. Continual verbigeration of unintelligible phrases suggests dementia præcox. With regard to conduct, marked degradation and sexual colouring apart from very deep clouding of consciousness is also in favour of that disease. Deliberate and clever malice at once puts pure amentia out of court. Negativism does not often occur apart from dementia præcox, but katatonia in some form would appear to do so in simple amentia in adolescents. I have not seen many such cases, and they have never been followed up after their apparent recovery.

It is not unknown for cases of actual dementia præcox to subside or remain latent for prolonged periods after an acute onset. One of the writer's doubtful types was a severe cardiac case with albuminuria and dropsy. Confusion with disorientation and almost complete inaccessibility existed with verbigeration, negativism, occasional mutacismus, dirty habits, and a mood of no very pro-

nounced colouring. There was of course cachexia. The onset had been acute, and the recovery was apparently complete and followed by amnesia for the attack. A previous attack had occurred a few weeks before with clouding of consciousness and apprehension, but without any signs of katatonia. Unfortunately a few months after recovering from the second attack, the man died from the cardiac condition. In cases of this sort with considerable clouding of consciousness, absence of emotional tone and reaction may be merely amential symptoms ; conspicuous and sincere emotional states however exclude dementia præcox.

In the milder attacks of confusion at the onset of dementia præcox, the characteristic features of the latter are sometimes difficult to make out and the cases very obscure. They are more like paranoidal amentia than any other single syndrome. There is confusion, disorientation, but complete accessibility and good simple perception. Memory for times especially is defective, and there is some impediment of thought. There is in some cases a sense of illness and not infrequently personal perplexity. Delusions mainly of persecution are present and conspicuous hallucinations, principally auditory. With all these features the mood is on the whole apathetic, and the emotional reaction markedly deficient. This basic apathy with complete accessibility is the key to the picture.

Stuporose cases in adolescents with clouding of consciousness may be either simple amentia attonita or dementia præcox combined with it. Complete dumbness and immobility may exist in both, together with inaccessibility. The features of dementia præcox are practically impossible to demonstrate in such cases. Symptoms to be carefully looked for are minor indications of katatonia such as strained or peculiar attitudes, negativism,

flexibilitas cerea, and causeless smiling. Another variety of confusional episode at the onset of dementia præcox is a sort of half-way house between the stuporose and excited types. It does not differ materially from the mild type described above. The patient is restless. He continually wanders about; never speaks spontaneously, and only replies in a word or irrelevantly when questioned. Hallucinations are less prominent than in the class previously described; delusions appear to be absent, but confusion and disorientation are present. Purposeless acts and other katatonic signs are much more obvious. The self-perplexed condition and the smile are usually in evidence. The mood is often superficially depressed and really indifferent. The main difference between these two mild types is that the second is more stuporose and more katatonic, and hence much easier to diagnose, than the first. One of the most important points in the recognition of dementia præcox in cases of confusion with or without katatonia is the previous history of the patient. If there is reliable evidence that his previous and life-long temperament was one of the reserved, reticent, solitary, studious but obstinate types, the chances are a hundred to one that dementia præcox is present.

Attacks of confusion in established cases of dementia præcox are not common. In asylums they usually mean auto-intoxication from constipation. They are naturally easy to distinguish from pure amentia as all their cardinal signs are present.

3. Hysteria and Dementia Præcox

Persons of hysterical temperament seldom develop dementia præcox. The main features of the latter, *e. g.*, apathy, non-suggestibility, absent or feeble emotional re-action, are directly opposed to the characters of

hysterics. Nevertheless one occasionally sees hysterical *episodes* in early cases of dementia præcox, especially the hebephrenic types.

The frequency of the association of hysteria and dementia præcox, however, is probably very much exaggerated, owing to the false identification of different symptoms, *e. g.*, perversity, with negativism ; hysterical weeping and laughing (in which appropriate emotions are present though transitory, and uncontrollable), with automatic emotional outbursts ; transitory aphonia, with mutacismus ; passionate but ideal eroticism, with blatant shameless sexuality (not merely a difference of degree, but of character ; the hysteric is erotic from great exaltation, the stress of passion breaking through a natural modesty ; the adolescent dement is erotic from absence of modesty, and moral cynicism). With regard to " attitudinizing " in hysteria and dementia præcox, the distinctions are again fundamental. In the former case the attitudes, etc., adopted are the result of emotional exaltation and they express very vividly the passion they represent. In dementia præcox they are motiveless, that is to say, not the result of emotions but of organic stimuli. Hysterical cases very commonly act in a most theatrical fashion ; their demeanour may change with great rapidity and without external cause ; but because they experience the emotions their conduct displays, they act very well. Cases of dementia præcox also occasionally act in a superficially similar fashion, but their performance is so execrable that it constitutes a burlesque—obviously insincere and often clownish—because they do not feel the emotions they profess to portray. Of course, much of the attitudinizing of hysteria is subconcious, the patients being in a state of dissociated consciousness easily distinguished from katatonia.

It is by these sorts of distinctions that dementia præcox may be recognized where it is associated with hysterical excitement at its onset. The obvious characteristic features of the disease, of course, would not be missed.

Nevertheless certain mixed hysterical and confusional cases are seen in which strong doubts about the co-existence of dementia præcox are only dissipated by the course. For example, when a case of traumatic "neurasthenia" (*i. e.*, hysteria, though naturally true neurasthenic symptoms may be present) suddenly becomes perverse, antagonistic, and though enjoying perfect perception makes ridiculous, but not meaningless, statements about persons and things, suffers from hallucinations, and becomes dirty in habits, one begins to entertain doubts concerning the nature of the malady present. Attacks of this sort are transitory if dementia præcox be not present, and complete recovery occurs in a few days. Such cases often show a certain degree of apathy during the attack, and I do not know any reliable means, except the course, of excluding a possible early adolescent dementia. Here again, however, the patient's previous temperament is of value. If it was of hysterical type the case is probably not dementia præcox; if it was of the dementia præcox type (*vide* p. 102) that disease is probably present.

4. Dementia Præcox and Epilepsy

That adolescent dements do occasionally suffer from true epileptic fits at very infrequent intervals is well known to asylum doctors. Patients of this sort are indistinguishable from ordinary cases of dementia præcox. The association is probably accidental. The present writer has never seen a case of dementia præcox with chronic epilepsy.

5. Alcoholic Syndromes and Dementia Præcox

As all the alcoholic psychoses are the result of chronic toping, and dementia præcox is mainly a disease of adolescence, combinations of these two conditions should be rare. This is found to be the case. A small number of the later developing types of dementia præcox manifest symptoms of chronic alcoholism; but these are also rare, which is perhaps rather remarkable in view of the assertion that the subjects of dementia præcox are "degenerates." It is not unlikely that there is another reason than age to account for this rarity, a reason associated with an inherent temperament in those especially liable to dementia præcox. Perhaps for persons of this temperament alcohol has no attractions. Be this as it may, there is, I think, no doubt that the common type of adolescent who subsequently develops dementia præcox is the quiet, studious, self-contained and rather seclusive youth—the stamp of young person who is addicted to masturbation and smoking rather than women and wine; another possible explanation is that alcohol in some way prevents the development of the metabolic disorder which is regarded as partly responsible for dementia præcox—a chemical theory. This appears much less likely on several grounds. Nevertheless neurasthenia, also regarded as in part due to auto-intoxication, is in many cases definitely benefited by moderate indulgence in alcohol.

In mixed alcoholic and adolescent demential psychoses the important point is of course to demonstrate dementia præcox, in some cases no easy task. One should, of course, be on the alert for the katatonic syndrome, signs of basic apathy, purposeless acts, meaningless speech, etc.

(B) MANIA ASSOCIATED WITH OTHER PSYCHOSES

Mania would appear to be found in combination chiefly with the following common syndromes :—

1. Melancholia.
2. Confusional attacks (*i. e.*, amential).
3. The psychoses of chronic alcoholism.
4. Hysteria.

1. Two combinations of mania with melancholia are described, viz. maniacal stupor and melancholic mania. The former has been described on page 95. The latter is said to present a picture of restless noisy melancholia, with press of occupation, rapid mental action, hypersensitiveness to external impressions, occasional remissions in the unhappiness, and divertibility, to varying extents.

2. Mania with Intoxication Symptoms

Confusional symptoms in severe acute mania are not uncommon as the attack proceeds, and when developed the case presents a picture sometimes indistinguishable from amentia agitata. The distinguishing features of the combined psychosis, when manifest, are as follows :—

Apprehension is transitory and may be absent, the mood for the most part being wildly exalted. Perception of the nature of objects is preserved. Hallucinations are not so all-absorbing as in severe amentia, and inaccessibility is much less pronounced.

With these divergences from amentia agitata, there is a degree of motor and emotional excitement equal to that found in that affection. In cases where the history is known a gradual onset of hypomaniacal type naturally excludes simple amentia.

3. Chronic Alcoholism

Certain cases are met with in which symptoms of mania are accompanied by alcoholic features and preceded by a history of chronic alcoholism. It is doubtful if such are to be regarded as purely alcoholic syndromes or combined psychoses in which the alcoholism has lighted up an attack of mania.

The so-called alcoholic mania (acute hallucinatory delusions) is usually not in the least like mania, but cases such as the following are not very uncommon :—

The patient is moderately excited and restless, manifesting press of occupation, and, when started off, garrulity with perfectly intelligible though incoherent speech, indicating considerable flight of ideas. The mood is one of exaltation and amicable hearty cheerfulness, quite free from apprehension. He expresses transitory delusions of persecution such as injury, mesmerism, etc., without showing any appropriate emotional tone. Illusions and hallucinations of hearing are present, with keen passive attention, complete accessibility, quick perception. Disorientation in time and space is present.

He is markedly divertible, and has a certain air of futility and childishness. Finally, some evidence of pseudo-reminiscence is not uncommon, together with physical signs of chronic alcoholism. Complete recovery ensues.

Cases of this sort are to be distinguished from maniacs with auto-intoxication (amential) symptoms, from general paralysis, and from chronic hallucinatory delusions (alcoholic) of hilarious type.

In the exhaustion pictures of mania, hallucinations are less prominent, in view of the excitement, both emotional and intellectual being more marked, and inaccessibility more pronounced, than is the case in these

alcoholic maniacs. In the latter the power of active attention is better preserved, and confusion is present from the onset, which is acute. Confusional symptoms in mania supervene gradually as the case becomes worse, and eventually produce a more acute picture of excitement with cachexia. To distinguish cases such as that described above from excited confusional attacks in early G.P.I. is by no means easy. Features of this latter to be looked for are expansive delusions and physical signs. It should also be borne in mind that hallucinations of hearing are rare in general paralysis apart from paralytic delirium, and that perception and passive attention are more active in the alcoholic state. That is to say, the alcoholic is generally more alert and his mental action is quicker than in the case of a paralytic of proportionate excitement and clouding of consciousness. Cases of paralytic delirium are much more deeply clouded and much less accessible.

With regard to chronic alcoholic hallucinatory delusions ;—in this condition disorientation, confusion about persons and environment and time, press of occupation, flight of ideas, and hyperacute passive attention, are absent. In short, neither the confusional nor all the maniacal symptoms are present.

Some further associations of alcoholism with manic-depressive syndromes will be noted under the title of complications of melancholia (p. 195).

4. Associations of Mania with Hysteria

Persons with a well-marked hysterical temperament appear to be rather more liable to attacks of mania than are normal persons, but the attacks are short and the prognosis is good.

In women, hysterical emotional symptoms are common

at the onset of mania, but the former should not be mistaken for the latter. Flight of ideas, divertibility, and press of occupation are not seen in hysterical excitement, moreover the extreme loss of control and emotional exaltation of the latter would only be found in severe cases of mania with all its cardinal symptoms well marked. Finally, pure hysterical paroxysms only last a few hours.

(C) MELANCHOLIA AND ASSOCIATED PSYCHOSES AND NEUROSES

Melancholia is not uncommonly found associated with—

1. Neurasthenia (including both types) and psychasthenia.
2. Mania.
3. Amential confusional episodes.
4. Chronic alcoholism.
5. Hysteria.

1. Melancholia with Psycho-Neurasthenia

Some notes on this subject in reference to differential diagnosis will be found on page 120.

Psycho-neurasthenia is not common in association with mania, but it is more commonly combined with melancholia than might appear to be the case at first sight, probably because in private practice cases of melancholia developing in the train of the other condition pass unrecognized, or at all events unnamed. It is the failure to recognize the onset of melancholia in acute neurasthenics that results in many cases of attempted suicide, for although indecision may be present, impediment of will is not at all marked in the early stages.

Continuous undivertible depression arising in cases of neurasthenia, depression unrelieved by intervals of relative comfort of mind due to cœnesthetic changes,

unalterable by pleasant environment in its fullest and happiest sense, and unrelieved by bed, indicates melancholia. Acute neurasthenics, however miserable, agitated and apprehensive, escape spontaneously from the deeps for short periods. Waves of alternate wretchedness and comparative comfort pass over them. Except in rare cases (see below) their apprehension never takes an external mental content; it is always a physical one, of impending death, insanity, or some ill-defined bodily catastrophe; and it is accompanied by physical signs of fear, *e. g.*, tremors, sweats, raised eyelids, dilated pupils, restlessness, palpitation. The development in such cases of a quiet fixed apprehension *pari passu* with the subsidence of physical agitation is indicative of the onset of melancholia, as is also self-depreciation in connection with the whole past, not merely specific incidents.

The blood pressure being low in acute neurasthenia and high in melancholia, one would expect to notice a change when the latter supervened. In reference to psychasthenic symptoms it has already been said that irrepressible ideas may develop in cases of melancholia into fixed ideas, viz. delusions (p. 122).

Cases are met with however in which such a transition occurs unaccompanied by deep continuous depression and impediment of will, but in which self-depreciation is present. It is sometimes found in these cases that the patient has always been of psychasthenic temperament; that as the result of some trauma (emotional) he has developed a mild attack of melancholia with delusions of psychasthenic origin; and that the state described above remains after partial recovery from the melancholia, the ideas persisting, when once fixed, owing to the incoercibility of psychasthenia.

Patients presenting such a picture should, however, be watched very closely indeed for signs of an early

dementia præcox. One should also bear in mind the question of paranoidal amentia, which does occasionally supervene upon psycho-neurasthenia, the diathesis of incoercibility, *i. e.*, psychasthenic temperament not uncommonly being found to have pre-existed in such cases. Confusion and hallucinations would occur when paranoidal amentia developed. Apart from combinations with melancholia, early dementia præcox, amentia, etc., there yet remains a class of case in which delusions develop directly out of psychasthenia and are accompanied by obsessive disorder of conduct.

These types, I think, justify the use of the term psychasthenic insanity. It is here suggested that the constitutional fearfulness of psychasthenia is incapable of spontaneously causing this psychosis, but that it may supervene upon some special emotional trauma sustained by a person of psychasthenic temperament.

Although the present writer does not believe in the invariably sexual theories on which it is endeavoured to base psycho-analysis, and is of the opinion that it is perfectly futile to psycho-analyze the ordinary melancholic or adolescent dement (though this is quite commonly done through lack of close clinical observation) [1]—that it is unnecessary and unkind to psycho-analyze neurasthenics, hysterics, and simple psychasthenics, that it is impossible to subject an ament or a paralytic to such a process—yet he believes that cases of psychasthenic insanity in which no cause can be found (*i.e.*, the trauma has been suppressed and forgotten) ought to be psycho-analyzed if hypnotic suggestion and other means fail.

[1] I have recently read of a case subjected for months to some sort of psycho-analysis and therapeutic talk, which to the author's distress produced little or no result. It is well described and is about as typical a case of longstanding dementia præcox as one could wish. A little clinical knowledge would have saved this futile waste of time.

Cases in which the trauma is discoverable should have the whole process explained to them, and be taught how to tackle both it and themselves.

2. Melancholia with Mania (*see* p. 189)

3. Melancholia with Confusional Symptoms

Some remarks on this subject have been made on page 53.

Confusional symptoms are met with both in agitated and stuporose melancholia. The main practical point is the recognition of such cases, so that confusion with totally distinct syndromes may be avoided.

For example, a continually depressed and emaciated person who lies about silent and inert and has to be urged to carry out the simplest acts of life, but who, in spite of disorientation and hallucinations, understands and after an effort slowly obeys simple commands, should not be mistaken for an alcoholic, an adolescent dement or an ament. Similarly, an acutely continuously miserable, restless and agitated woman, who hears the voices of her children calling to her, and thinks that she is doomed to eternal damnation or speedy death because she has neglected them—who refuses her food, ties her night-dress round her neck, wails and wrings her hands, but who does nothing illogical in view of her emotional and ideational state, and replies naturally when questioned—is suffering from melancholia with exhaustion symptoms.

4. Melancholia with Chronic Alcoholism

Cases are met with in which apparent alcoholic syndromes are accompanied by an unusually constant and continuous state of depression, together with impediment

of will, or in which apparent melancholics manifest definite signs of chronic alcoholism. In some of them a history of previous attacks of depression is forthcoming, or a history that the alcoholism has resulted from a generally gloomy outlook upon life.

Typical cases show a marked misery deepening into melancholic stupor. In these the main feature is the melancholia. Intervals of relative cheerfulness showing the semi-humorous mood; hallucinations, and other alcoholic features, indicate a superimposed alcoholism. In other cases the alcoholic symptoms are the more prominent.

For example, there may be dull apprehensive depression, and impediment of will—showing itself in silence, sitting about alone, slow re-action to questions—together with conspicuous hallucinations of hearing, delusions of persecution, good perception, complete accessibility and understanding of the *status quo*, and physical signs of alcoholism, and the dull, coarse, degraded, hang-dog appearance of the chronic alcoholic.

Whether any melancholic element is present in cases of this sort is mainly of academic interest. Such patients do not recover, but as the course proceeds the depression becomes less, and eventually the semi-humorous mood develops. Probably those with a previous history of melancholic attacks, or of previous hypo-melancholia, are partly of melancholic origin.

Another variety of case is encountered in which the stupor, though not the depression, is much more pronounced. Patients of this class manifest much less prominent hallucinations and apprehensive depression, but on the other hand more confusion, with disorientation and marked general amnesia more conspicuous for recent incidents. They stand about silent and apparently indifferent to their surroundings. When addressed they

mutter or do not reply at all. Yet they are obviously miserable.

Later, the amnesia, confusion, and depression suddenly or gradually pass off, and in their place appears a transitory phase of euphoria, alertness, and exuberance, followed by a return of dull depression with hallucinations of hearing and delusions of persecution, but complete collectedness. The erroneous ideas take the form of injury by unseen means or enemies. Amnesia for the confusional state remains. With all these features there is a history of alcoholism (as well as signs of it), and also of previous attacks of depression alternating with cheerfulness (when everything seems bright and easy), both of minor degree, hardly over-stepping the bounds of the normal.

Psychoses of this sort are very difficult to diagnose until they are cleared up by their course.

The most likely solution appears to be the supposition of a combination of maniacal-depressive insanity with hallucinatory alcoholic delusions, acute in the early confused state, chronic later. Possibly some other intoxication of unknown origin co-exists in the initial confusional attack.

5. Melancholia and Hysteria

Hysterical depression and weeping, apart from melancholia, may, if prolonged, lead to the suspicion of melancholia. It is not however characterized by steady misery, but by sudden changes, lightenings, and sometimes occasional laughter, followed by showers of easily shed tears. There is an exaggerated emotional reaction and general instability of mood, moreover the unhappiness is not very deep in spite of its pronounced expression. In melancholia such outward show of unhappiness would only

occur in pronounced unmistakable cases. Hysterical depression *per se* is never accompanied by impediment of will.

True melancholia in hysterical persons is shorter, more demonstrative, and less severe than in uncomplicated cases.

The development in a case of hysteria of persistent depression with impediment of will indicates the onset of melancholia, just as it would in a person not of hysterical temperament.

4. COMPLICATED COMBINED PSYCHOSES

Three or more mental syndromes may naturally be associated in one individual, but the association is not very common. From the brief account of double syndromes given above, not by any means exhausting the possibilities of such combinations, aided by a thorough clinical knowledge of well-defined single psychoses, the attainment of some idea of the clinical pictures produced by complicated types will be possible. The exact diagnosis, however, of some of them will always remain a difficult task, only to be facilitated by careful study of actual cases. The complex manifestations of them cannot be predicted merely from a theoretical knowledge of the symptoms found in the component psychoses, combined with an acquaintance with psychology, for it is found that apparently incompatible psychological disorders do, in fact, exist in one case. Nevertheless the combinations possible are not susceptible of extension *ad infinitum.*

Careful record of combined cases as they are encountered should be kept by all alienists, so that their nature and limits, the influence of one symptom upon another, may eventually be determined, and not only will precise clinical knowledge be enriched thereby, but our under-

standing of the psychology of the insane and sane mind considerably enlightened.

Some conception of the involved nature of the subject will be gathered by consideration of the possibility of a combination, for example, of mania with exhaustion symptoms, or amentia or chronic alcoholic syndromes, occurring in an imbecile suffering from paranoical tendencies; or a case of periodic mania in an alcoholic manifesting epileptic fits; or a paranoiac developing neurasthenia at the onset of G.P.I.

At present cases of this sort can, for the most part, only be elucidated by a thorough knowledge of the patient's history and by observation of the course of the disorder.

ALPHABETICAL GLOSSARY OF TERMS EMPLOYED

1. ACCESSIBILITY :

   The state or condition in virtue of which a person's attention can be claimed and his understanding activated by external agents.

2. AMIMIA :

   Loss of facial expression due to muscular paresis.

3. AMNESIA :

   Loss of memory.

4. ATTENTION :

   The state of an individual when placed in the best attitude to receive sensations from an object perceived or experienced by the senses.

   (*a*) Active attention (syn. Voluntary attention). The state when achieved by an action of will.

   (*b*) Passive attention (syn. Involuntary, instinctive attention), the state when brought about without conscious volition, *i. e.* having the attention claimed by an external stimulus.

5. AUTOCRITICISM :

   The faculty of understanding one's own condition.

6. AUTOMATIC OBEDIENCE :

   (*a*) Echopraxis.

   Purposeless repetition of the actions of others.

   (*b*) Echolalia.

   Purposeless repetition of the speech of others.

   (Both conditions mainly occur in dementia præcox.)

7. Catalepsy :
   (*a*) Flexibilitas cerea.
   A condition in which a person's limbs, etc., remain for considerable periods in any position in which they are placed by another.
   (*b*) Automatic obedience (*vide supra*).

8. Cœnesthesis (*see* Euphoria).

9. Comprehension :
   Used in this book to indicate understanding of what is said.

10. Confusion of Speech :
    Meaningless unintelligible talking, often with disintegration of words (*cf.* Incoherence).

11. Disorientation :
    Absence of knowledge of position with regard to place or time.

12. Divertibility :
    The quality in virtue of which the mood, thoughts, or conduct can be influenced by the suggestion of others, or by external stimuli.

13. Echolalia, Echopraxis. *See* Automatic Obedience.

14. Equivalents :
    (Psychical or motor, in epilepsy.)
    States occurring instead of, or in association with, epileptic fits. They are sudden, short, periodical, frequent, causeless, and similar in those of the same type.

15. Euphoria :
    A feeling of personal well-being dependent upon the pleasantness of the sum total of unrecognised bodily sensations, *i. e.* of the Cœnesthesis.

16. Hallucination :
    Imaginary perception (*vide infra*). An hallucination is a pathological percept or sensation occurring without the presence of external stimuli to produce it.
    (*a*) Elementary hallucinations, *e. g.* flashes of light, ringing in the ears, etc.
    (*b*) Organized hallucinations, *e. g.* imaginary voices, figures, etc.
    (In this book the term hallucination used alone indicates organized hallucination.)

17. Ideation :

The process by which a former percept (or percepts), rises into consciousness. An idea is a percept revived in the mind by association in the absence of the external stimuli, which gave rise to the original percept, *i. e.* in the absence of the object producing the stimuli (*vide* perception *infra*), *e. g.* in a simple form ; one sees a tart which by association evokes the idea of apples.

Concepts or conceptions are general ideas of abstract nature, in fact, abstractions, *e. g.* darkness, light, good, evil.

18. Ideational Inertia :

The persistence of an idea and its application to objects other than that from which the percept giving rise to the idea was derived, *e. g.* a patient is shown a cup of tea, then a coal-scuttle (which he knows is a coal-scuttle) the idea "cup of tea" persisting, he says the coal-scuttle is for holding cups of tea : a cupboard, for storing cups of tea, etc.

19. Illusion :

Erroneous perception. Perception of one object when the sensations experienced arise from another.

20. Imperception :

Absence of perception. Inability to combine sensations arising from an object to form a percept—a single mental picture of that object ; *e. g.* if a man sees, smells, and handles an orange, but does not know what it is, in spite of former experience of oranges, he is suffering from imperception.

21. Incoherent Speech :

Speech composed of detached phrases, disconnected or unfinished sentences, which is nevertheless intelligible and an expression of ideas.

22. Katatonia :

A disorder of conduct in which actions result from abnormal internal stimuli and not motives. The term is used loosely.

As defined above, some degree is always present in Dementia Præcox. In its usual sense it means especially, minor motiveless actions, such as purposeless movements of limbs, etc., rigid attitudes and absurd poses. It is also used to indicate the variety of dementia præcox in which these symptoms and those mentioned below, (*a*) and (*b*) are prominent. Katatonia includes the special symptoms :—

(*a*) *Negativism.* A condition in which any external stimuli to action give rise to internal stimuli producing action of an opposite nature.

(*b*) *Stereotypism.* Multiple repetition of the same movements or forms of speech : in the latter case called verbigeration.

Katatonia in well-marked forms is almost peculiar to dementia præcox.

23. Mannerisms—in Dementia Præcox.

A minor indication of Katatonia, *i. e.* purposeless tricks of manner, gestures and speech, peculiar stiff, affected or pedantic fashions of carrying out ordinary acts.

24. Mentation :

Used in this book to indicate mental action in general.

25. Mutacismus :

An example of negativism—forced dumbness.

26. Negativism :

Vide Katatonia *supra*. Examples : a patient asked to show his tongue, clenches his teeth. Requested to shake hands, puts his behind him : neither acts being the result of personal resentment or of any motive at all.

27. Neologism :

Coining of new words. This may be to supply a want, *e. g.* to describe a mode of imaginary persecution in paranoidal cases ; or the neologism may have no ideational content, as sometimes occurs in Dementia Præcox.

28. Obsessions :

Imperative impulses to action, which meet with resistance on the part of their subject (*see* Psychasthenia).

29. Orientation :

Knowledge of one's position in relation to time and space (*cf.* disorientation).

30. Perception :

The process by which existing sensations arising from an object present, are combined to form a mental unity peculiar to that object, *e. g.* an apple giving rise to sensations, visual, tactile, olfactory, etc., enables one to experience a concrete percept "apple," which is capable by a process of association of being revived as the idea of an apple in its absence, *e. g.* by seeing a pie or a fruit knife (*vide* Imperception and Ideation, *supra*).

By combining simple percepts and ideas, complicated percepts and general ideas are produced, *e. g.* one sees a long room full of beds, tidy and clean, with tables bearing bottles of medicine, and medical appliances ; these individual percepts and the ideas to which they give rise by association are combined and one apprehends that the room is a hospital ward. Inability so to combine, results in disorientation.

31. Press of Occupation :

A condition resulting in continual action.

32. Pseudo-hallucinations (Auditory).

"Audible thought." These hallucinations are peculiar to dementia præcox. The essential practical difference between them and true hallucinations is that their subject does not localize them externally to himself ; *i. e.* they do not sound the same to him as actual voices. Varied descriptions are given by a patient subject to these, *e. g.* his thoughts are repeated ; others project their thoughts into his head. But their internal nature remains constant.

33. Pseudo-reminiscence :

Falsification of memory. "Recollection" of incidents, etc., that have not occurred.

34. Seclusiveness :

Desire for or purposeless impulse towards solitude.

35. Stereotypism, *vide* Katatonia (*supra*).

36. Syllable Stumbling:

Stuttering and elision and transposition of syllables in G.P.I. Tests: "Irish Artillery," "Compulsory Registration."

37. Verbigeration:

Vide Katatonia (*supra*).

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Butler & Tanner, Frome and London.